# Synthesis Research on Community Capacity

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The views expressed herein do not necessarily represent the views of Health Canada.

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## Operationalizing & Measuring Community Capacity


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# MAIN MESSAGES

Community capacity building is a multi-sectoral phenomenon used by a wide variety of professionals with disparate skill sets, in many settings to address many topics. While it is widely believed that community capacity building is a useful process and that it has the potential to extend the health system's capacity, there is currently no uniform approach, and many questions remain unanswered. The entire community capacity building process needs greater rigor and standardization. Community capacity building may be of particular relevance in communities of elderly citizens where capacity building can compensate for loss of individual capacity and health system shortfalls. To date very little, if any, work has been done in this area. Health Canada has the opportunity to provide leadership in this area by bringing key partners together, increasing rigor and "setting the standard" for health-related community capacity building initiatives.

*Recommendation 1:* Create, implement and support a national "Integrated Strategic Planning Group" for community capacity building.

Create a national integrated strategic planning group that includes a "lead" person from each of Health Canada's existing branches, augmented by a minimum of 1 representative with high credibility and experience in working with communities from each of the following sectors: (1) health service partners (e.g., Community Care Access Centres (CCACs); etc.); (2) community-based funders (e.g., Trillium Foundation; United Way; etc.); (3) academic institutions; and (4) the corporate sector. This group should be led by an *external* visionary leader, and be brought together monthly physically and/or electronically to co-ordinate a national strategy for community capacity building as it relates to Health Canada's mandate. This strategic planning group should (a) examine in detail the key components of community capacity building, (b) develop national community capacity practice guidelines, (c) develop regional, provincial and national guidelines implementation strategies, (d) support a number of key demonstration/pilot projects, and (e) apply knowledge transfer principles to disseminate this information to ensure uniformity, increased rigor and standardization in community capacity building at all levels.

*Recommendation 2:* Create and implement a uniform "4-tiered" funding process for all community-related health initiatives.

This "4-tiered" funding process should include: (1) first-stage program development funding (for up to 1 year) to allow applicants to build a solid foundation and plan for their community work; (2) actual project funding (up to 3 years); this should require re-submission by appplicants and will depend on results of stage 1 including the evaluation structure (i.e., processes shown to work and interim outputs relevant to final project objectives); (3) process improvement/sustainability funding (2-4 years) applicants must provide evidence that their approach works (outcomes are being achieved) and is generalizable, demonstrate continual improvement and begin to build sustainability; and (4) a post-sustainability/ accountability review, if the program achieves sustainability and is integrated into the existing "system", to ensure that the original philosophy, guiding principles and outcomes are being maintained over the long-term.

*Recommendation 3:* Continue to implement and strengthen knowledge transfer strategies to disseminate community capacity building information, tools and resources in a uniform way regionally, provincially and nationally. Create, support and maintain a resource base for community capacity building initiatives.

# MESSAGES PRINCIPAUX



La capacité de bâtir en communauté est un phénomène multi-sectoriel utilisé par une grande variété de professionnels ayant des habiletés différentes, dans diverses sphères, dans le but de répondre à des besoins variés. Alors qu'il est grandement compris que la capacité de bâtir en communauté est un processus utile et qu'il a le potentiel d'améliorer la capacité du système de santé, en ce moment il n'y a pas d'approche commune et plusieurs questions demeurent sans réponse. Le processus entier de la capacité de bâtir en communauté a besoin d'une plus grande rigueur et standardisation. La capacité de bâtir en communauté peut avoir une pertinence particulière dans les milieux de citoyens âgés où la capacité de bâtir peut compenser pour la perte de capacité individuelle et des déficits du système de santé. Jusqu'à présent, très peu, sinon aucun travail n'a été fait dans ce domaine. Santé-Canada a l'opportunité de fournir le leadership dans ce domaine, en réunissant des partenaires-clés, augmentant ainsi la rigueur et « établissant les standards » pour les initiatives de la capacité de bâtir en communauté.

*Recommandation 1:* Créer, implanter et appuyer un «groupe planificateur de stratégies intégrées» au niveau national pour la capacité de bâtir en communauté.

Créer un groupe planificateur de stratégies intégrées au niveau national qui inclurait une « personne-clé » venant de chacune des divisions existantes de Santé-Canada, en plus d'un minimum de 1 représentant ayant une grande crédibilité et expérience à oeuvrer dans les milieux de chacun des secteurs suivants: (1) partenaires du service de santé (e.g. Centres d'Accès aux Soins Communautaires (CCACs); etc,); (2) fondations à base communautaire (e.g. Fondation Trillium; United Way; etc.); (3) institutions dans le secteur de l'enseignement; et (4) le secteur corporatif. Ce groupe devrait être dirigé par un leader externe possédant une grande vision, et devrait se réunir mensuellement en personne et/ou par voie électronique afin de coordonner une stratégie au niveau national pour la capacité de bâtir en communauté selon les objectifs du mandat de Santé-Canada. Ce groupe planificateur de stratégies devrait (a) examiner en détail les composantes-clés de la capacité de bâtir en communauté, (b) développer des directives pour la capacité de bâtir en communauté, (c) développer aux niveaux régional, provincial et national des directives de stratégies d'implantation, (d) appuyer un certain nombre de démonstrations-clés/de projets- pilotes, et (e) se servir des principes de transfert de connaissances pour diffuser cette information afin d'en assurer l'uniformité, la rigueur et la standardisation accrue au sujet de la capacité de bâtir en communauté, à tous les niveaux.

*Recommandation 2:* Créer et implanter un processus uniforme de financement à «4 paliers» pour toutes les initiatives de santé reliées à la communauté.

Ce processus de financement à «4 paliers» devrait inclure: (1) un financement de développement de programme de base (maximum 1 an) afin d'aider ceux qui en font la demande d'établir une base solide et de planifier leur oeuvre communautaire; (2) le financement du projet même (maximum 3 ans); les personnes concernées devraient en refaire la demande et le financement dépendra des résultats de l'étape 1, incluant la structure de l'évaluation (e.g., les processus qui ont bien fonctionné et les objectifs atteints jusqu'à date à l'intérieur des objectifs du projet final); (3) l'amélioration dans les processus/le financement pour le maintien (2-4 ans); les personnes qui en font la demande

d'établir une base solide et de planifier leur oeuvre communautaire; (2) le financement du projet même (maximum 3 ans); les personnes concernées devraient en refaire la demande et le financement dépendra des résultats de l'étape 1, incluant la structure de l'évaluation (e.g., les processus qui ont bien fonctionné et les objectifs atteints jusqu'à date à l'intérieur des objectifs du projet final); (3) l'amélioration dans les processus/le financement pour le maintien (2-4 ans); les personnes qui en font la demande doivent fournir la preuve que leur approche fonctionne (les objectifs sont atteints) et peut se généraliser, et doivent démontrer une amélioration continue et commencent à bâtir quelque chose de solide; et (4) un futur maintien/un compte-rendu, à savoir si le programme se maintient et est intégré à l'intérieur du «système» existant, afin d'assurer que la philosophie originale, les principes directeurs et objectifs soient maintenus à long terme.

*Recommandation 3:* Continuer à implanter et à affermir les stratégies de transfert de connaissances afin de diffuser l'information concernant la capacité de bâtir en communauté, les outils et les ressources d'une manière uniforme aux niveaux régional, provincial et national. Créer, appuyer et maintenir une base de ressources pour les initiatives de la capacité de bâtir en la communauté.

# EXECUTIVE SUMMARY

In May 2002 Health Canada, through the Health Policy Research Program, provided funding to analyze community capacity building trends, identify issues and gaps and to provide practice guidelines that can be used to inform policy decisions related to community capacity building. Communities of old and very old individuals are one of the fastest growing segments of the population and are among the heaviest users of health services. Community capacity building may have particular relevance for communities of elderly individuals[1,2,3] to compensate for loss of individual capacity to and to extend the health system's reach particularly in the area of providing supportive services. The recent emphasis on community capacity building is timely and appropriate given the limitations of the community care system and the ongoing demands that will be placed upon that system by the increasing numbers of frail elderly individuals in very near future. Community capacity building is in its early stage of development, especially in the area of health care, and in particular as it pertains to the elderly. We drew on our combined experiences with (1) the Cherryhill Healthy Ageing Program, a collaborative program designed to develop, implement and evaluate a new and innovative model of community health for the elderly, (2) the "Models Project" an award-winning initiative which involved the creation of geriatric expertise in health care communities in southwestern Ontario, and (3) "Investing in Children", one of five provincial demonstration sites for the "Early Years Project" developed to promote early childhood health and facilitate the development of policy related to the health of children. Our research consisted of an extensive literature review and analysis of published cross-sector articles and unpublished reports related to community capacity building, a community capacity "think-tank" involving a wide health practitioners, funders and policy-makers involved in capacity building, and a survey of community capacity projects. Our evidence-based and experiential findings confirm that there is a lack of "rigor" in the area of community capacity building and that this and many other issues must be addressed before the value of this approach within the health context can be accepted.

### OUR FINDINGS:

- there are currently no universally accepted definitions, processes, or evaluation indicators for community capacity building; terminology is used inconsistently and often incorrectly; it is quite common for projects to use the term community capacity building but not to practice the principles intrinsic to the definition

- there are no uniform, consistent and universally accepted practice guidelines to guide community capacity building in general, or within a health context

- there is currently no consistent theoretical foundation or infrastructure for community capacity building; community capacity building to date has progressed by a process of experience and "case law"; a number of key authors have attempted to identify critical/core components of the community capacity building process[4,5,6,7,8] however much of this appears to be occurring "piece-meal" and lacks a co-ordinated approach at the national level

- there is an inherent assumption that community capacity building is valuable however evaluation is deficient; outcomes at the "collective" community level or community-system level are almost non-existent

- there is a dearth of information regarding indicators and outcome measures applicable to communities of elderly individuals and health promotion programs for the elderly and evaluation of such programs is deficient

- the field is characterized by significant shortfalls in evaluation; projects focus on the process and rarely reach the outcomes; this may in part be because of the time frames involved (long timeframe, short funding cycle); although many components and a multitude of indicators have been identified the field lacks a standardized approach to evaluation and has, to date, not produced a step-wise process that will allow projects to be built in an evidence-based manner

- our attempt to survey the current practice in Canada met with limited success; the few respondents to our survey identified no evaluation indicators that were geared to capture achievement o capacity at the community (macro) level

- our experience to date reinforces that there are clear parameters for community capacity building with older individuals living in the community; there are clear boundaries to what community members/communities are willing and able to do in a health context; *"one approach (e.g., community capacity building) does not fit all situations"*; there are such a diversity of communities and health topics that no one approach is the best; currently we lack any clear way of defining the characteristics of communities, health issues; the type of approach most likely to be effective; or the potential role of the community

## *Our Recommendations:*

- the health system would greatly benefit from practical guidelines, which are evidence-or theory-based, or at least based in national consensus which health professionals, funders and policy-makers could draw upon, selecting processes and evaluation indicators most appropriate for their area of interest; we feel it is critical at this stage that best practices and models within this field, including composite evaluation indicators reflecting both process and outcomes, be agreed upon,

- common and agreed-upon language needs to be developed; the critical elements of each level of community work need to be defined and incorporated with the Health Canada terminology and granting requirements; a clear expectation of the level of community involvement needs to be spelled out as it can range from true partnerships to responding to a survey

- evaluation expectations and uniform evaluation guidelines and indicators should be developed to guide community-related initiatives; a structure for the development of an evaluation framework is proposed

- it should be an essential component of any application for funding that the guidelines be recognized and followed; in the absence of a solid evidence base the guidelines based in theory and practical-based experiences (consensus) will serve to guide the field

- the Ministry will need to review its funding process, including the application of guideline-based critical review and the recognition of the time lines such projects require; a process of sequential funding should be developed that will allow the evaluation of each step before the next attracts funding

- it is recognized by practitioners that the sustainability of an initiative by its incorporation into the system can be problematic; standards and a review process need to be developed

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# CHAPTER 1: WHY IS THIS IMPORTANT?

## INTRODUCTION

Financial constraints and shrinking health care resources have resulted in new challenges in health care service delivery in Canada. Diminishing acute care resources have led to earlier discharge from hospital placing increasing strain on the community care system. Inevitably the elderly, the greatest consumers of the health care system, bear the brunt of such changes. In addition, limitations in the long-term care system have led to older, sicker, elderly clients remaining in the community longer, again, placing more demands on the community care system. The failure of the latter to grow to meet these demands has led to an increasing restriction on the less professional services such as homemaking, although there is evidence that such peripheral supports help old people remain in the community longer. In Ontario these changes have been reflected in a series of system-sponsored documents.[9,10,11,12,13]

At the same time, community capacity building from a health care and maintenance perspective has received increasing attention. A particular emphasis has been placed on self-help modes of community development that enhance the capacity of populations to improve and maintain their health.[14,15,16,17] There is, therefore, the potential for the latter process to begin to compensate for the shortfalls becoming apparent in the formal system. Ideally, the two "systems", the formal health care system with it's emphasis on illness and evidence-based practice,[18,19,20,21] and the community system with its broader perspective on health and wellness, should work collaboratively. How best to do this is the challenge.

An added challenge for an already burdened health care system is the rapid growth in the elderly population, in particular the anticipated growth surge in individuals 75 years of age and older, who have a greater number of health problems and who are major consumers of health care services. Seniors prefer to maintain their independence in the community rather than in expensive long-term care and acute care facilities. Many health professionals, however, are questioning the community health system's "readiness" to cope with this influx of frailer, older individuals with multiple and complex health problems. The problems experienced by frail elderly individuals are often seen as problems for the health-care system to solve. Thus, the locus of control for frailer individuals is not only external to themselves, but external to the community as well. Creating and maintaining capacity in aging communities where the health of even the most active and involved citizens is somewhat precarious, will be an ongoing challenge for researchers, policy-makers and health professionals. Capacity at the community level may be particularly important when capacity at the individual level may be declining or impaired. Building upon the available health-related community capacity knowledge, and evidence base related to a frailer, older population should be an overall health care and policy goal for Health Canada.

## The Problem & Is Community Capacity Building The Answer?

Population Projections, Demographic Trends & the Cost of Health Care:

The number of elderly individuals living in the community, particularly those 75 years of age and older, is increasing.[22,23,24] The number of individuals 85 years of age and older, is expected to increase 115% by the year 2016.[22] Currently 50% of such people are housebound.[25] This aging population is already challenging the community health system which is increasingly stressed to provide all the required daily services such as house cleaning, meal preparation, personal care and assistance with shopping. Additionally, the evidence points to the need for frailer older people to be provided with a greater degree of monitoring and surveillance in order to prevent, or respond rapidly to, declining health and function.[26] Once again, the system will have difficulty accommodating this need. A reasonable alternative would be to look at the community within which one lives, and to explore whether healthier and more active community members and communities themselves have the capacity to take responsibility for their frailer neighbours.

Additionally, the current health system is constructed and funded in "silos" with individual agency mandates and regulations. This structure is not designed to deal with the ongoing needs of frail older people. It cannot provide the level of supervision and follow-up required by a population characterized by a multiplicity of problems and instability.[27] Canada has one of the most expensive health care systems in the world.[28] A thorough review of this area is provided by Leibowich, Bergman and Beland.[28] A critical conclusion is that our health care system requires better co-ordination and integration at the community level. In Canada, there is no specific accountability for the optimal care of the elderly over time. Efforts elsewhere to avoid these problems have led to such projects as the Darlington Project in the United Kingdom,[29] the well known "On Lok" Project in San Francisco, the "Choice Project" in Edmonton and the "SIPA" Project in Quebec.[30]

Current Health Care Trends & The Way of the Future in Geriatric Care:

Notable recent changes in health care include an increased emphasis on community health services and supports[22,31,32,33,34,35] and community mobilization and collaboration around health issues, with a particular emphasis on self-help models such as community development and community capacity building.[36,37,38,39,40] This puts some of the responsibility for health care planning and provision back into the hands of individuals and their communities, but very few health studies and projects have explored how this might be done. In parallel

with this movement to community involvement and governance in health care, various models have increased the focus on health promotion and prevention.[41,42,43,44,45,46] In these models, however, the community is not involved in the planning or delivery of care. Community development and community capacity building approaches imply that community members participate collaboratively in the assessment, planning, development, and delivery of services.

Our Experience: The Cherryhill Healthy Ageing Program (1996-2003):

The Cherryhill Healthy Ageing Program[27,47,48] has been extensively involved in community capacity building and measuring community capacity in a community of frailer, older adults since 1996, and has much scientific and experiential data to draw on. The Cherryhill community in London, Ontario has a high concentration of seniors and is an area of high health service utilization. It consists of 13 privately owned apartment buildings housing over 2500 seniors over 65 years of age (mean age=79 years ± 9.53 SD) and 64 local businesses. In the past 2-3 years multiple geriatric service partners have been working collaboratively to develop, implement and evaluate a new and innovative inter-disciplinary and inter-agency model of community health care for the elderly using a theoretically-based community-systems approach. Cherryhill Healthy Ageing Program goals include:

- helping older individuals remain active, engaged & in their own homes
- creating a sustainable system of joint community & health system decision-making
- exploring how seniors can become involved in planning & providing their health services
- building capacity to respond to community & system-identified health issues
- building & strengthening existing, untapped community health resources;

our 7-year process included collaboratively examining:

1. *the population/community* (e.g., demographics; growth projections; health problems; apartment building manager perspectives)
2. *the health system* (e.g, system gaps; system needs; model development)
3. *building community capacity* (e.g., examining the role of community members as an extension to the health system; what they are able and willing to do)
4. *linking the community and health system* (i.e., developing the inter-disciplinary, inter-agency partnership model & examining whether health agencies and service providers can change the way they do business to share health-related decision-making and develop a "true" partnership with a community)

*1. Our Findings: The Population/Community*: Characteristics of this population include an increasing number of elderly individuals who are unstable, isolated, have an increasing number of health problems and a decrease in function, in a state of risk and have limited access to health care.[27] Many have limited capacity physically and/or mentally.

*2. Our Findings: The Health System*: Two key findings to date[5] are limitations in health system capacity and design. The system as currently operating is challenged to cope with the many problems of the rapidly growing aging population. The current system also is not designed to deal with the "horizontal" or continuing care needs of frail, older people and cannot provide the level of supervision and follow-up required. There are many interfaces, little continuity of care, and too little information flow. The following provides an example of needs in the Cherryhill community and our local city-wide system's capacity to address these needs:

| Cherryhill Health Problems | | System Capacity | |
|---|---|---|---|
| ▫ number of incontinent residents | 300 | ▫ number seen in Continence Clinic 2001-2002 | 56 |
| ▫ number who could benefit from a comprehensive geriatric assessment | ± 300 | ▫ number Day Hospital has seen in the past year | 220 |
| | | general geriatric clinics | 393 |
| ▫ number with cognitive impairment | 400+ | ▫ number seen in Aging Brain Clinic | 146 |
| ▫ number who fall per year | 750+ | ▫ number a falls clinic could see per year | ±100 |

Not only is system capacity a local concern, it is also a regional concern for the 10 counties in southwestern Ontario. For individuals ≥ 65 years of age, it is recognized that 15% could benefit from a comprehensive geriatric assessment and this rises markedly with age.[49] The following regional data highlight examples of regional system capacity inadequacy for people 75 years of age and older in southwestern Ontario:

| County | Population 2000 | Population 2010 | Percent seen for Assessment (2001) |
|---|---|---|---|
| Middlesex | 24,364 | 28,337 | 1.2% |
| Huron | 4,968 | 5,431 | 1.6% |
| Oxford | 6,954 | 8,096 | 2.4% |

For frail older individuals instability is the rule and ongoing attention is the answer to prevent premature nursing home admissions and functional decline in elderly people.[26]

*3. Our Findings: Building Community Capacity*: During the past 7 years we have accumulated much evidence regarding the role of community members, how to integrate the community into the health system, and whether a community can extend the health system's capacity and provide some of the ongoing or "horizontal" requirements (e.g., monitoring; identifying "at-risk"; supportive services; etc.) so critically required by the aging population. We have demonstrated the degree to which older volunteer community members can be involved, where their comfort level is, and what they cannot, and do not wish to be involved in.[27] At the start of the project a survey identified the range of services well elderly community members could provide for frailer neighbours (e.g., shopping; cleaning; minor repairs; etc.). After 6 years of involvement with the project their perception of what they could offer has changed. Members now see their role to monitor the health status of their neighbours, identify those "at-risk", build relationships, trust (reduce fear and suspicion) and link those "at-risk" with the health system. They can facilitate quicker, friendlier and targeted access to the health system, provide social support, help plan and run psychosocial and maintenance programs as well as helping their neighbours with light housekeeping, meal preparation, and more.[27] Neighbours are capable of helping and willing to help, and a community can come together as an effective source to help those "at-risk".

*4. Linking Health System and Community*: A new partnership model is now in place in the Cherryhill community to begin collaboratively to address health issues identified. The Division of Geriatric Medicine, Specialized Geriatric Services, University of Western Ontario, CCAC London-Middlesex, St. Joseph's Health Care London, Community Care Access Centre (CCAA) London-Middlesex and Victorian Order of Nurses (VON) London-Middlesex have made a commitment to work collaboratively to integrate evidence-based community prevention, maintenance, clinical and rehabilitation programs, using a new and integrated inter-disciplinary, inter-agency approach, with a shared vision and shared decision-making with the Cherryhill community. This is still in its infancy and needs resources to be done.

When help is needed by individual community members, the community and its citizens can, and should take collective and personal responsibility to work both independently, and with the formal health system, to deliver the required health support in the best and most economical way. Too often the health provider and recipients of health care services are just that, providers and recipients, active and passive. Providers deliver what and how their mandate dictates, frequently with limited versatility, and recipients gratefully take what they are entitled to. Health is a continuum that covers a wide range of issues from individual freedom, prevention of

disease and disability, to community vitality and self-determination. It cannot be segmented into stand-alone parts for the convenience of agencies of service delivery or mechanisms of funding. There is much to be gained from communities and the health care system working together, and there is a need to understand how the current funding system can obstruct progress.

While community capacity building around health issues is a growing trend, there are many gaps (1) in current community development and capacity knowledge, (2) in the measurement of community capacity, and (3) in the selection of the most effective approaches for engaging citizens and communities in collaborative health planning. Documentation on the feasibility of community capacity building, particularly with communities of very old individuals with complex health conditions is sparse. Likewise, evaluation and measurement approaches to determine the success (or lack thereof) of community capacity building initiatives and the sustainability of these initiatives vary greatly. Current measurement practices range from no evaluations being conducted, to anecdotal report of project benefits, to simply tracking the numbers of individuals involved or number of programs implemented without evaluating the collective capacity of a community to identify their issues, mobilize the necessary resources and address social and public health problems.

## The Potential Benefits of Capacity Building

The potential benefits of capacity building with communities of frailer, older people are great. While the aging process itself is not reversible, there are many factors in the lives of elderly individuals, which, with the appropriate intervention and supports, can optimize the health and functional ability of even the frailest members of our society. There is much that can be done from both (a) a longer-term "futuristic approach" where the health of a community in the future can be enhanced through the early provision of prevention and health promotion programs, (b) a shorter, more immediate "intervention approach" such as rehabilitation, providing adaptive equipment, or other supports to optimized the health, functional ability, independence and quality of life of elderly individuals living in the community, and (c) ongoing monitoring. Community members, individually and collectively, have many strengths which often remain untapped due to lack of information, knowledge or skills. Helping elderly individuals take control of their health and strengthening informal community health supports around them, coupled with a formal health system that is committed to greater versatility, flexibility and shared governance, may have the potential to significantly improve the health of community elderly. The empowered community can take its place along side the health care system in a model referred to as a community systems approach. The interaction of the community and the health system is essential in any health-related focus. Regrettably the system is usually not a

seamless continuum of care, but a segmented, frequently disjointed and sometimes competitive collection of health agencies. This highlights the need for the system to develop in such a manner that it can work with the community in a co-ordinated fashion raising the need for collaborative partnerships and different working models.

## Building Community Capacity

Community capacity refers to the ability of a community to harness its skills, knowledge and resources to collectively work with, in this case, the formal health system to determine action around community- and system-identified health issues. Community capacity implies a shift of "power" from the traditional "top-down" approach (health system/professionally drive approach) to shared decision-making, negotiating and problem solving among all partners (i.e., community and formal health system). It also implies long-term community management of community-identified issues.

Working with communities to build capacity is a time intensive and challenging process that facilitates new learning and changes in attitudes and behaviours by all partners involved, including community residents and partner health agencies. While time intensive up front, community capacity building has many paybacks and benefits over the long term. Working with communities to build capacity requires skills and knowledge of relevant theoretical frameworks that enhance/constrain capacity building initiatives (e.g., change theory; theories of aging; social psychological theories; theories of volunteerism; etc.) and perseverance.

Often, during capacity building initiatives, there is pressure from the various partners (e.g., community; agency partners; funders; etc.) for immediate action and tangible results and outcomes. This was experienced many times during the more than 6 years of operation of the Cherryhill Healthy Ageing Program. Knowledge of the key factors impacting the success/failure of change initiatives (e.g., timing; communication processes; unique characteristics of one's community; etc.) as identified in the various theories is very important in order to establish realistic time lines, identify community leaders, establish the required working committees and determine communication processes based on the unique needs of the particular community one is working with. Each of these factors will impact the short-term success and longer term sustainability of community initiatives. Core components of the community capacity building process include[50]:

- identifying common issues, needs, goals, etc.
- working collaboratively & co-operatively
- building inter-agency & cross-sector partnerships

Sustainability of community capacity building initiatives is dependent upon many factors, both internal and external, to the communities with which one works. Increasingly, available evidence suggests that success is dependent upon having adequate time to work with a community, the ability to mobilize community resources, stable and visible community leaders, a formal leadership structure and general leadership facilitated by someone with knowledge and training in community capacity building processes and the various related theoretical frameworks. The greater the perception of collaboration, connectedness and involvement in the decision-making, the greater the community's sense of ownership and the more positive the outcomes.

## Research Questions & Methodology

1. Current Knowledge-Base:

   - $RQ_1$: What is the definition of community capacity across sectors and how is community capacity operationalized?
   - $RQ_2$: What are the theoretical underpinnings of community capacity?
   - $RQ_3$: Are there innovative statistical and analytical methods which can be applied to measuring community capacity?

2. What is Being Used in Actual Practice:

   - $RQ_4$: What types of community capacity approaches and community capacity evaluation indicators are currently being used across a variety of disciplines and sectors?
   - $RQ_5$: How sensitive are these indicators to capturing change at the *collective community level*?
   - $RQ_6$: Are these indicators applicable to communities of elderly individuals?

3. Successful Models & Emerging Practices:

   - $RQ_7$: Are there best and emerging cross-sector practices and models that have been demonstrated to be successful in developing and measuring community capacity?
   - $RQ_8$: Can a composite of indicators reflecting both process and outcomes, and based on theoretical construct, be recommended for future testing?

Our approach consisted of a review, analysis and synthesis of published and unpublished community capacity literature (outlined in detail in Chapter 4), and a survey of existing community capacity building projects (outlined in detail in Chapter 6). Published literature was evaluated using established criteria for assigning levels of evidence. We adapted established criteria currently used for developing clinical practice guidelines, including criteria for assigning levels of evidence and grades of recommendations.[50] From the literature review and levels of evidence, we hoped to develop recommendations with strength of evidence supporting the recommendations. For evaluation of projects, we used a definition of best practice provided by the Best Practice Network:

> *"A best practice is a service, function or process that has been fine-tuned, improved and implemented to produce superior outcomes. 'Best' is used in a contextual sense. It means 'best' for your patients or your community — in the context of your regional health environment, your health system's strategies and mission, your organizational or community culture, or your practice systems. Best practices are those practices that result in benchmarks that meet or set a new standard."*[51]

This definition emphasizes that the term "best" is context specific, raising many challenges for concepts so broad as "health" and "community".

# CHAPTER 2: POLICY IMPLICATIONS

The implications of the recommendations made as a result of this work are quite fundamental. It is our impression that community capacity building, as a discipline, is still in its early stages of development, although enough experience and evidence has been accumulated to permit the bringing together of a body of knowledge to form the basis of a discipline. Although community capacity building is perceived as having many benefits, its precise value in the field of health and health promotion is still unclear. On the basis of current evidence we do not feel that the methodology is sufficiently proven as to become an accepted way for Health Canada and provincial mandates of health to do business. More proof is required and studies should be funded with the specific purpose of testing the value of the approach.

Health Canada should also sponsor the development of guidelines for health care providers to enable them to work better with communities. These should include everything from administrative structure and accountability to specific skill training for community-based health care workers. There will be implications for provincial health initiatives which frequently legislate both the responsibilities of the agencies, their mode of operation and accountability, that can make the development of innovative models difficult.

Within the narrower concept of health, and specific initiatives within this (e.g. smoking cessation; treating hypertension; etc.), it needs to be decided what methodology within the spectrum of community action (e.g., community-based programs; community mobilization; community capacity building; etc.) best suits different health initiatives. Again, a move to bring together expertise in the field to define the components of health and the community initiatives most relevant for each component, along with the process, indicators and overall evaluation framework, would move the field forward. Analysis and clarification of these large and unwieldy concepts (community action, health, empowerment and so on) will help the field in the development of a research program which will build the body of best practices in this area to guide the field forward.

There are implications for the field of health or relevant to the provincial mandates and Health Canada. The concept of "health" is so broad as to almost have become meaningless. Health Canada needs to define its field of interest within the concepts of health and health promotion. For example, although disease prevention is an obvious mandate for Health Canada, it could be agreed that reducing poverty, although important for health is not. This raises the question of whether the concept of community capacity building crosses sufficient areas of policy and requires an inter-departmental approach.

There are also implications for the funding process. The critical elements identified are the pre-project assessment, the project and its process and

achievement of interim and subsequently final goals (evaluation), and the post-project sustainable phase. Each of these should be recognized within the call for proposals and funding should be provided in a step-wise fashion. The developed guidelines should inform both the application and the review process but it is essential that studies be funded to further build the evidence-base and evolve the guidelines accordingly. This process will entail that money is spent on "doable" projects, following a specific process, having an adequate evaluation and with a definable goal of relevance to Health Canada's mandate.

It is critical that a post-project surveillance system be devised. Successful programs that achieve sustainability must have their critical elements retained. This becomes a critical issues when programs are integrated into existing structures and systems (both community and health systems) and new or different individuals continue the program. Changing the program to better suit the administrative and bureaucratic structure of the system, which frequently happens, may compromise the program. A post-sustainability surveillance program is needed, with the commitment to discontinue funding if the key elements of the program are lost.

Health Canada should fund an initiative whereby a critical appraisal process, similar to levels of evidence in scientific studies, can be developed. Such a process is critical for best practices to be developed. It is important that developments in community capacity building be shared with other funders, as there is a wide range of funders interested in the field. It would be useful for linkages between the different funders to be formed. Much is done that is never made available through publication in other than foundation specific reports. Some form of central repository of projects, containing an abstract and main lessons would help spread knowledge. This could be web-based.

Guidelines for the publication of initiatives in community capacity building projects are essential, and should be applied by Health Canada to their funded projects and advocated to peer-and non-peer reviewed (including funder reports) publications. This would greatly increase the utility of these reports. The expert committee suggested could undertake this as it would naturally fall out of the guidelines initiative. The collaboration of the editors of journals which publish such reports should be sought.

# CHAPTER 3: IMPLEMENTATION OF FINDINGS

*Recommendation 1:* Create, implement and support a national "Integrated Strategic Planning Group" for community capacity building.

Create a national integrated strategic planning group that includes a "lead" person from each of Health Canada's existing branches, augmented by a minimum of 1 representative with high credibility and experience in working with communities from each of the following sectors: (1) health service partners (e.g., Community Care Access Centres (CCACs); etc.); (2) community-based funders (e.g., Trillium Foundation; United Way; etc.); (3) academic institutions; and (4) the corporate sector. This group should be led by an *external* visionary leader, and be brought together monthly physically and/or electronically to co-ordinate a national strategy for community capacity building as it relates to Health Canada's mandate. This strategic planning group should (a) examine in detail the key components of community capacity building, (b) develop national community capacity practice guidelines, (c) develop regional, provincial and national guidelines implementation strategies, (d) support a number of key demonstration/pilot projects, and (e) apply knowledge transfer principles to disseminate this information to ensure uniformity, increased rigor and standardization in community capacity building at all levels.

*Implementation:*

- indentify across government departments the level of interest in community capacity building
- identify across Canada those with recommended expertise in the field, crossing the academic, service, funding and provincial policy areas
- the group can be informed by representatives from the business community as the subsequent process can be designed as a business model/plan
- begin the process with a 2-3 day strategic planning conference to develop a strategy and time lines for the work inhand
- action team leaders for each section identified can be elected and each action team leader should have the freedom to build his/her own committee (for example, skills required by a community evaluator, relevant indicators for health in older life, could be specific tasks)
- a sub-committee will be required for building the linkages across the country with funders and other policy makers and determining the best method of knowledge transfer and dissemination
- part of the strategic planning conference should entail the development of a budget for the overall process
- the outcome of this process will be an evidence- and concensus-based set of guidelines for different community initiaties, a knowledge transfer and dissemination process, and an ongoing process to maintain the guidelines

*Recommendation 2:* Create and implement a uniform "4-tiered" funding process for all community-related health initiatives.

This "4-tiered" funding process should include: (1) first-stage program development funding (for up to 1 year) to allow applicants to build a solid foundation and plan for their community work; (2) actual project funding (up to 3 years); this should require re-submission by appplicants and will depend on results of stage 1 including the evaluation structure (i.e., processes shown to work and interim outputs relevant to final project objectives); (3) process improvement/ sustainability funding (2-4 years) applicants must provide evidence that their approach works (outcomes are being achieved) and is generalizable, demonstrate continual improvement and begin to build sustainability; and (4) a post-sustainability/accountability review, if the program achieves sustainability and is integrated into the existing "system", to ensure that the original philosophy, guiding principles and outcomes are being maintained over the long-term.

*Implementation:*

Based on the outcome of Recommendation 1, Health Canada should review its funding mechanism into 2 streams:

1. along the lines of a business model to fund implementation projects which aim to work with communities on a specific health issue where the epidemiology, management/treatment of the problem is well known, but there are care gaps or shortfalls in implementation of the available evidence

2. a more exploratory stream where projects designed to fill gaps in the evidence and the evidence-based guidelines can obtain funding

Each stream will be dependent upon the guideline development process. For stream (1) the project must follow the guidelines; for stream (2) the project must relate to gaps identified by the guidelines committee.

*Recommendation 3:* Continue to implement and strengthen knowledge transfer strategies to disseminate community capacity building information, tools and resources in a uniform way regionally, provincially and nationally; create, support and maintain a resource base for community capacity building initiatives

*Implementation:*

Effective knowledge dissemination and utilization consists of 2 key components[52,53]:

1. knowledge source & a transfer mechanism
2. knowledge utilization (which requires a behaviour change by knowledge recipients and additional resources to facilitate/support this behaviour change)

Evidence has shown[52] that a partnership between knowledge source and potential knowledge users is critical and that linkages to bridge knowledge gaps between the source and potential users are key to facilitating knowledge transfer. A collaborative participatory approach to developing knowledge transfer and implementation strategies, training materials, etc. has been identified as the key for getting "buy in" and motivating behaviour change. Ways to facilitate "ownership" of the new information by users should also be sought. Health Canada, through an "Integrated Strategic Planning Group" (Recommendation 1) should:

- develop and maintain a database of regional, provincial and national funders, service providers, policy-makers and others interested in community capacity building
- develop a "knowledge transfer team" with regional, provincial and national representation which includes both representation from the Integrated Strategic Planning Group and potential users of community capacity-related information (funders, health professionals, policy-makers) to (a) collaboratively develop knowledge transfer and implementation strategies, and (b) disseminate national guidelines-related information, tools and other resources
- this will require ongoing financial support for both the preparation and packaging of hard copy/electronic community capacity-related information (including administrative & technical support), as well as resources/ financial support for implementation by potential knowledge users
- community capacity-related information for dissemination can be received from all sources, be peer-or guidelines committee reviewed, disseminated on a regular basis electronically (web-based) or otherwise

# CHAPTER 4: LITERATURE REVIEW & ANALYSIS

## THE PROCESS

Existing guidelines and processes for conducting research synthesis were reviewed[54,55] and a framework was developed to ensure a systematic, comprehensive and impartial review of published and unpublished literature related to community capacity building in the context of health planning, service delivery and policy. The following section outlines in detail:

- how published and unpublished literature was identified for potential inclusion
- literature search and retrieval strategies
- selection criteria for inclusion
- analysis and interpretation of selected studies
- synthesis of published and unpublished literature

While broad inclusion criteria were employed, the searches, by necessity, were restricted to English-language publications. Findings of the literature review and analysis were used to guide the development of the community capacity building project survey, along with the combined experiences of:

(1) *The Cherryhill Healthy Ageing Program:* a community capacity project which examined (a) whether a community of frailer, older individuals is able and willing to do to extend the health system's capacity by becoming involved in health services planning, delivery and evaluation, and (b) whether health service providers and agencies can change the way they do business to share health-related decision-making and develop a "true" partnership with a community to better respond to community- and system-identified health needs.

(2) *Investing in Children:* one of five provincial demonstration sites for the "Early Years Project" developed to promote early childhood health and facilitate the development of policy related to the health of children.

(3) *London Inter-Community Health Centre:* a local health agency which specializes in multi-cultural issues.

## 4.1 Identification of Articles & Reports

A framework (derived from the research questions & theories relevant to community capacity building outlined in Chapter 1, and the experiences of the research team during the past 7 years) was developed to identify search terms and inclusion criteria for the articles and reports (Table 1).

Table 1: Framework of original search terms.

| CONTEXT | POPULATION OF INTEREST | COMMUNITY CAPACITY-RELATED TERMS | EVALUATION TERMS |
|---|---|---|---|
| Community Health | Seniors | Community Capacity Building | Evaluation |
| | 85+ years | Community Development | Measurement |
| | 75-84 years | Community Partnerships | Outcomes |
| | 65-74 years | Community Action | Outcome Indicators |
| | 55-65 years | Community Empowerment | |
| | | Community-Driven | |
| | Children/Youth/Teens | Community Participation | |
| | Early Years (0-6 years) | Community Engagement | |
| | Youth (7-12 years) | Community Involvement | |
| | Teens (13-18 years) | Community Building | |
| | | Community Systems Approach | |
| | General – Adults | Participatory Action Research | |

In addition the terms "theory" and "conceptual framework" were searched in combination with the above.

Terms were searched individually and in combination. Both published and unpublished articles and reports were included in the search and retrieval process. A variety of inter-disciplinary and cross-sectoral databases were identified and searched to ensure comprehensiveness and to reduce potential bias. A librarian was consulted, asked to review the list of databases, and asked to identify any potential omissions. Specifically the databases identified and searched included:

- PubMed
- CINAHL
- ERIC
- Sociology Abstracts
- PsychInfo & EMBASE Psychiatry
- Social Work Abstracts Plus
- Ageline
- Social Sciences Citation Index

In addition an on-line internet search, using the same search terms and criteria, was conducted to identify and retrieve unpublished community capacity building project reports. Reports mentioned in published articles were also retrieved.

An initial pilot search conducted by the research assistants yielded an extremely unwieldy number of responses and many inappropriate articles bearing no relationship whatsoever to community capacity building as defined by this project. For example, an initial search in PubMed using only a sampling of the search terms produced the following number of titles:

| Search Terms | Number of Titles |
|---|---|
| Community Development | 14,601 |
| Community Action | 16,243 |
| Community Action & Health | 10,436 |
| Community Participation | 16,559 |
| Community Participation & Health | 10,711 |

This was not an unexpected occurrence, as breadth and depth of search terms, along with study limitations related to community capacity building projects, have been identified as a challenge by other researchers.[54]

Following the pilot search, initial terms and the inclusion criteria were modified. Databases searched remained the same. Modified primary search terms used in this research project are outlined in Table 2. Each of these primary search term was searched individually and in combination with 5 "sub-terms". The following inclusion criteria were applied:

Inclusion Criteria for the Literature Search

1. Search time frame: January 1, 1993 - October 31, 2002
2. Human based studies only
3. NOT an individual focus (focus of title reflects "community")
4. NOT a patient (focus of title reflects community projects outside of traditional patient-care settings)

Table 2: Modified search terms used in the present research project.

| PRIMARY SEARCH TERMS | | SUB-SEARCH TERMS |
|---|---|---|
| Community Capacity Building | searched individually & in combination with the 5 sub-terms | Measurement |
| Community Development | | Evaluation |
| Community Action | | Theory |
| Community-Driven | | Conceptual Frameworks |
| Community Partnerships | | Health |
| Community Participation | | |
| Community Engagement | | |
| Community Systems Approach | | |
| Community Building | | |

Table 3 provides literature search results and the number of "hits" for individual primary search terms as well as primary search terms in combination with the 5 sub-terms. All titles (n= 49,037) were reviewed by the research assistant. Within these search results, and across the various data bases, a significant number of duplicate titles were identified. Also, the databases varied in their options for delimiting searches. For example, the ERIC database did not control for human vs. animal studies and also included unpublished reports. Thus, at times it was not possible to apply the same standardized across the databases. The research assistant reviewed all titles, eliminated duplicates, identified all titles that were remotely relevant to the project at hand, and discarded those obviously not suitable for inclusion. The following provides an example of titles flagged for in inclusion and those discarded:

> "*A multi-project systems approach to developing community trust and building capacity.*" (flagged for inclusion)

> "*Chinese dementia specialist education program: training Chinese American health care professionals as dementia experts.*" (discarded)

While the latter title turned up in the search results due to one or more of the search terms being embedded within the abstract or article itself, the focus of the article obviously differed from that of the project at hand. Abstracts were obtained (either in hard copy format or on-line) for all "flagged" titles. All titles related to measurement, evaluation, theory and/or conceptual frameworks related to community capacity building or a similar construct were forwarded to the principal investigators for review and to determine whether abstracts and the full article should be retrieved. All titles mentioning any of the above terms in combination with community capacity building or a related term were flagged for retrieval. Results of these articles are outlined in subsequent sections.

Table 3: Modified literature search results.

| SEARCH TERMS | PUBMED | PSYCHINFO & EMBASE PSYCHIATRY | CINHAL | SOCIAL WORK ABSTRACTS | ERIC | AGELINE | SOC. ABSTRACTS | SOC. SCI. CITATION INDEX |
|---|---|---|---|---|---|---|---|---|
| **Community Capacity Building** | 169 | 7 | 29 | 4 | 100 | 2 | 0 | 0 |
| measurement | 0 | 0 | 4 | 0 | 2 | 0 | 0 | 0 |
| evaluation | 1 | 1 | 14 | 0 | 60 | 0 | 0 | 0 |
| theory | 6 | 1 | 13 | 0 | 6 | 1 | 0 | 0 |
| conceptual framework | 2 | 1 | 1 | 0 | 1 | 0 | 0 | 0 |
| health | 144 | 1 | 29 | 2 | 37 | 1 | 15 | 6 |
| **Community Development** | 1815 | 43 | 601 | 658 | 17388 | 384 | 0 | 0 |
| measurement | 81 | 0 | 43 | 10 | 194 | 3 | 0 | 0 |
| evaluation | 0 | 3 | 246 | 49 | 3881 | 24 | 0 | 0 |
| theory | 469 | 1 | 213 | 52 | 952 | 2 | 0 | 0 |
| conceptual framework | 26 | 0 | 3 | 8 | 141 | 1 | 0 | 0 |
| health | 1026 | 33 | 532 | 86 | 1826 | 180 | 888 | 186 |
| **Community Action** | 2244 | 18 | 208 | 74 | 4340 | 126 | 0 | 0 |
| measurement | 273 | 1 | 11 | 0 | 33 | 0 | 0 | 0 |
| evaluation | 0 | 3 | 98 | 8 | 761 | 18 | 0 | 0 |
| theory | 414 | 0 | 65 | 5 | 332 | 1 | 0 | 0 |
| conceptual framework | 4 | 0 | 1 | 0 | 38 | 0 | 0 | 0 |
| health | 1869 | 15 | 185 | 14 | 559 | 57 | 222 | n/a |

Table 3: Modified literature search results cont'd.

| SEARCH TERMS | PUBMED | PSYCHINFO & EMBASE PSYCHIATRY | CINHAL | SOCIAL WORK ABSTRACTS | ERIC | AGELINE | SOC. ABSTRACTS | SOC. SCI. CITATION INDEX |
|---|---|---|---|---|---|---|---|---|
| Community Driven | 22 | 2 | 14 | 1 | 16 | 3 | 0 | 0 |
| measurement | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| evaluation | 5 | 0 | 8 | 0 | 3 | 0 | 0 | 0 |
| theory | 2 | 0 | 6 | 0 | 1 | 0 | 0 | 0 |
| conceptual framework | 0 | 0 | 2 | 0 | 1 | 0 | 0 | 0 |
| health | 19 | 1 | 12 | 1 | 9 | 3 | 3 | 16 |
| Community Partnerships | 727 | 7 | 216 | 9 | 4281 | 21 | 0 | 0 |
| measurement | 14 | 0 | 7 | 0 | 44 | 0 | 0 | 0 |
| evaluation | 0 | 0 | 82 | 1 | 938 | 2 | 0 | 0 |
| theory | 17 | 0 | 60 | 0 | 91 | 0 | 0 | 0 |
| conceptual framework | 2 | 0 | 12 | 0 | 17 | 0 | 0 | 0 |
| health | 633 | 6 | 203 | 5 | 381 | 11 | 79 | 56 |
| Community Participation | 2378 | 35 | 315 | 47 | 5297 | 152 | 0 | 0 |
| measurement | 836 | 1 | 25 | 1 | 54 | 0 | 0 | 0 |
| evaluation | 342 | 3 | 148 | 2 | 1092 | 21 | 0 | 0 |
| theory | 418 | 1 | 106 | 3 | 216 | 4 | 0 | 0 |
| conceptual framework | 43 | 0 | 30 | 0 | 7 | 0 | 0 | 0 |
| health | 1975 | 28 | 295 | 10 | 472 | 92 | 358 | 330 |

Table 3: Modified literature search results cont'd.

| SEARCH TERMS | PUBMED | PSYCHINFO & EMBASE PSYCHIATRY | CINHAL | SOCIAL WORK ABSTRACTS | ERIC | AGELINE | SOC. ABSTRACTS | SOC. SCI. CITATION INDEX |
|---|---|---|---|---|---|---|---|---|
| Community Engagement | 186 | 2 | 10 | 4 | 357 | 7 | 0 | 0 |
| measurement | 10 | 0 | 3 | 1 | 2 | 0 | 0 | 0 |
| evaluation | 34 | 0 | 4 | 0 | 58 | 0 | 0 | 0 |
| theory | 9 | 0 | 7 | 1 | 33 | 1 | 0 | 0 |
| conceptual framework | 3 | 0 | 3 | 0 | 0 | 0 | 0 | 0 |
| health | 129 | 1 | 9 | 0 | 33 | 5 | 22 | 2 |
| Community Systems Approach | 759 | 1 | 3 | 1 | 696 | 6 | 0 | 0 |
| measurement | 32 | 0 | 0 | 0 | 13 | 1 | 0 | 0 |
| evaluation | 137 | 0 | 1 | 0 | 189 | 1 | 0 | 0 |
| theory | 61 | 0 | 0 | 0 | 66 | 0 | 0 | 0 |
| conceptual framework | 11 | 0 | 0 | 0 | 16 | 1 | 0 | 0 |
| health | 552 | 0 | 2 | 0 | 98 | 5 | 90 | 0 |
| Community Building | 1636 | 11 | 289 | 26 | 3217 | 73 | 0 | 0 |
| measurement | 69 | 0 | 25 | 0 | 33 | 0 | 0 | 0 |
| evaluation | 245 | 0 | 109 | 1 | 546 | 8 | 0 | 0 |
| theory | 71 | 1 | 117 | 3 | 194 | 5 | 0 | 0 |
| conceptual framework | 16 | 0 | 30 | 1 | 28 | 0 | 0 | 0 |
| health | 1114 | 8 | 240 | 4 | 326 | 22 | 107 | 14 |

## 4.2 Selection of Articles & Reports for Inclusion

All relevant abstracts were reviewed (either in hard copy format or on-line) by the research assistant to determine suitability for inclusion in the research synthesis process.

One potential source of bias in synthesis research is the evidence and/or methods used to select articles for inclusion.[54,55] Of interest to the current research synthesis project, were articles and reports focusing on "community" projects, that is projects which involved populations, communities and community members in a collaborative way using community capacity building, community development, community action and/or community mobilization principles. Every attempt was made to ensure comprehensive and substantive inclusion criteria with standards for acceptable cross-sector (not just a health) evidence. The selection of potentially eligible articles for full review and synthesis was guided by the following process.

### Foundations, Source & Nature of the Evidence

Formal definitions of community capacity building (and related concepts) taken from the work of leading researchers in this area (Table 4), along with existing models and relevant theories, guided the selection process. Drawing on the various concepts and definitional frameworks provided by the researchers listed in Table 4, a set of inclusion indicators was developed to guide the abstract review process and the selection of full articles and reports. The research assistant read all abstracts. If there was any mention or indication of any of the concepts outlined in Table 5, the full paper was requested for inclusion in the research synthesis. A cross-sector focus was used.

Following abstract review by the research assistant, all articles identified for full review and inclusion were obtained by printing directly from online sources, ordering from the library, or photocopying directly from the journal. Throughout the review process, additional articles were identified by examining citations provided at the end of each journal article reviewed. Those identified for inclusion were obtained by the same means outlined above.

Unpublished reports were also of interest and felt important to include in the research synthesis. Unpublished reports were identified through references in published journal articles, a comprehensive web/internet search using the same search terms, the ERIC database (which includes unpublished reports), and from the personal contacts and experience of the research team. All relevant unpublished reports were obtained for potential inclusion in the research synthesis.

Table 4: Concepts and definitional frameworks related to community capacity.

FOUNDATION & SOURCES OF THE EVIDENCE

COMMUNITY CAPACITY BUILDING/COMMUNITY DEVELOPMENT

- Hawe, King, Noort, Jordens & Lloyd, 2000[56]
- Goodman, Speers, McLeroy[57]
- Chaskin,[58]
- Labonte, 1989[59]
- Sheill & Hawe, 1996[60]
- Kretzman & McKnight, 1993[61]
- Ontario Healthy Communities Coalition, 1998[62]
- Perkins & Zimmerman, 1995[63]
- Labonte et al, 2002[64]

COMMUNITY SYSTEMS APPROACH

- Shields, 1997[65]

VOLUNTARY PARTICIPATION/DETERMINANTS OF LOCAL ACTION

- Chavis & Wandersman, 1990[66]

COMMUNITY EMPOWERMENT/PARTNERSHIP BUILDING

- Eisen, 1994[67]
- Hawe, 1994[68]
- Wallerstein, 1992[69]
- Labonte, 1989[59]
- Rappaport, 1981[70]
- Rappaport, Swift & Hess, 1984[71]
- Zimmerman & Rappaport, 1988[72]
- Zimmerman, 1990[73], 2000[74]
- Bracht, Kingsbury & Rissel,[75]

Table 5: Community capacity building concepts used to guide article selection.

| Community Capacity Building & Related Concepts |
| --- |
| ▫ working with communities/community members to build program infrastructures |
| ▫ building community partnerships & environments which facilitate program sustainability |
| ▫ building problem-solving capacity within the community |
| ▫ citizen participation |
| ▫ citizen/community empowerment |
| ▫ citizen/community leadership |
| ▫ sense of community |
| ▫ social networks & inter-organizational relationships |
| ▫ community resources |
| ▫ citizens working together |
| ▫ building skills, knowledge & resources |
| ▫ community-driven action |
| ▫ community involvement |
| ▫ voluntary participation/local action/community coalitions |
| ▫ notion of empowerment & transferring control |
| ▫ power "shift" |
| ▫ voluntary collective action to produce change |
| ▫ equal & shared decision-making |
| ▫ negotiating & problem-solving |

The complete citation for all articles identified for inclusion was entered into a computerized database, using Reference Manager 10 software. Databases were created to include articles/reports "on hand" and a series of databases were created to track orders being processed by the library, and articles identified as available at the local university and, therefore, accessible for quicker acquisition via direct photocopying. As articles were obtained, they were moved from their respective "order" databases into the "root" database (of articles on hand). Each article was assigned a reference manager identification number. This number was recorded on the article itself and was later used to track the evaluation of the article.

A total of 457 articles and/or reports (published and unpublished) were selected for potential inclusion in the research synthesis based on the abstract reviews. This included 425 published articles and 32 unpublished reports. Of the 457 full articles/reports retrieved, the following were selected for inclusion in the present research synthesis based on their relevance to community capacity building:

| | |
|---|---|
| Published journal articles | 210 |
| Unpublished project reports | 16 |
| | 226 |

In addition to the 226 articles and reports, 140 articles which focused on the specific topics of measurement, evaluation, theory and conceptual frameworks related to community capacity building were forwarded to the principal investigators for independent review and inclusion in the present study:

| | |
|---|---|
| Measurement & Evaluation | 86 |
| Theory | 7 |
| Conceptual Frameworks/Models | 47 |
| | 140 |

The total number of articles and reports related to community capacity building included in the current research synthesis was 366.

## 4.3 Analysis & Interpretation of Selected Articles/Reports

An analytic framework was developed to assist with the systematic review and critical appraisal of all articles and reports related to community capacity projects selected for full review (n=226). Development of the analysis criteria, both quantitative and qualitative, was guided by the research questions (please see Chapter 1), existing theories, models and conceptual frameworks related to this area, as well as the experience of the research team and recommendations of other researchers studying this area. These criteria were used to create an analysis form (Appendix A) that was used by the research assistant for critical appraisal of all articles and reports. The analysis form contained the following primary and sub categories:

| PRIMARY CATEGORY | SUB-CATEGORIES |
|---|---|
| 1. Information Source | ▫ published literature (peer-reviewed)<br>▫ published literature (non peer-reviewed)<br>▫ unpublished literature<br>▫ web-based information<br>▫ verbal/written information from key stakeholders & other key informants |
| 2. Foundation of the Project | ▫ geographical location<br>▫ primary source of funding<br>▫ target population<br>▫ project goals<br>▫ project timelines |
| 3. Project Design | ▫ definition of community/how community is operationalized<br>▫ theoretical framework used to guide the project<br>▫ approach used<br>▫ level of involvement by community<br>▫ process used to involve the community |
| 4. Policy Considerations | ▫ governance structure of the project<br>▫ citizen/public representation & involvement |
| 5. Research & Evaluation | ▫ research/project methodology<br>▫ evaluation/outcome indicators<br>▫ level of evaluation/unit of analysis<br>▫ standardized measurement/evaluation tools |
| 6. Major Obstacles/Barriers | |
| 7. Innovative Ideas & Approaches | |

The analysis form was pilot tested three times prior to use in the research synthesis to assess it's ease of use, effectiveness in capturing the required information and to test inter-rater reliability. The initial form was pilot tested by the two principal investigators and one research assistant. Each of the investigators and research assistant independently completed an analysis form for the five randomly selected published articles. Once completed the process and form were discussed and revised. Following the initial pilot, test questions were re-ordered, two evaluation questions, open-ended questions were added to two quantitative questions to clarify important concepts (e.g., definition of community; approach used), and a project summary checklist were added. The revised analysis form was then tested again by the two research assistants. Five articles were again randomly selected and both research assistants independently completed an analysis form for each of the same five articles. There were slight differences between the two researchers. For two questions, across all five papers, there was a discrepancy as to whether only one box was to be checked or all that apply. This was rectified by going through the form and clearly stating when only one box was to be ticked. In two of the five papers, there were differences in how the level of involvement of the community was recorded. All questions were reviewed and clarified with the research assistants, in particular, the question related to level of involvement was clarified. To avoid any guesswork, the category "not enough information provided" or "did not specify" was added as an option to three questions on the form. Research assistants were instructed to record only what was written in the article, not to leave blanks, not to make judgments re: "best fit" of answers, and to check the "insufficient information" category if unsure. An additional five articles were randomly selected for one last pilot test prior to the actual research synthesis. This time, the forms independently completed by the two researchers for each of the five articles reviewed were identical in their ratings.

Once the final version of the analysis form was approved by the research team, the analysis of articles and reports for the research synthesis (n=226) began. Articles and reports were read in no particular order, an analysis form was completed for each of the 226 articles and reports, and all full references were entered into the Reference Manager 10 computerized database and assigned an identification number by the research assistants. A database was created using SPSS 10.0 for Windows. All information on the analysis forms was entered into this computerized database.

## 4.4 Synthesis of Information from Selected Articles & Reports

### Results

A total of 226 articles and reports were included in the review and analysis of community capacity related projects. Of the 226 projects, 67% were peer-reviewed publications, 26% non-peer reviewed publications, 6% unpublished reports or site developed documentation, and 1% web-based information (Figure 1).

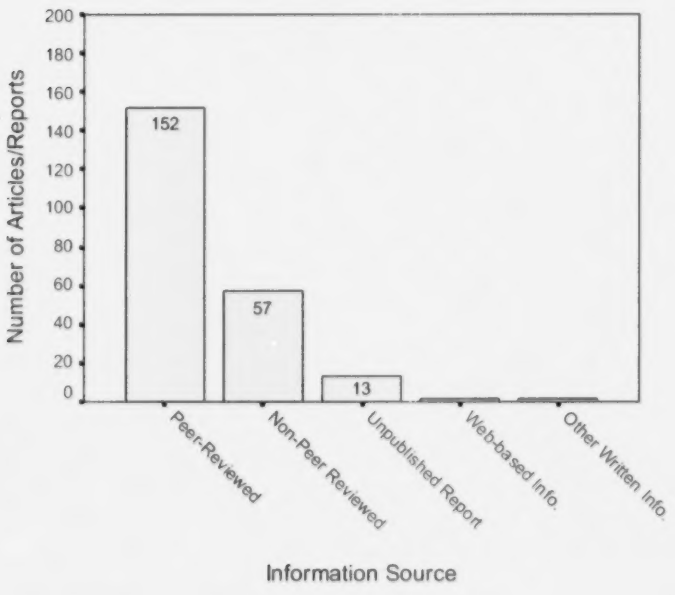



Figure 1: Sources of project information.

Projects included in the research synthesis represented 23 countries (Figure 2), with many projects from both Canada and the United States. Nine Canadian provinces were represented (Figure 3) and 32 U.S. states were represented (Figure 4).

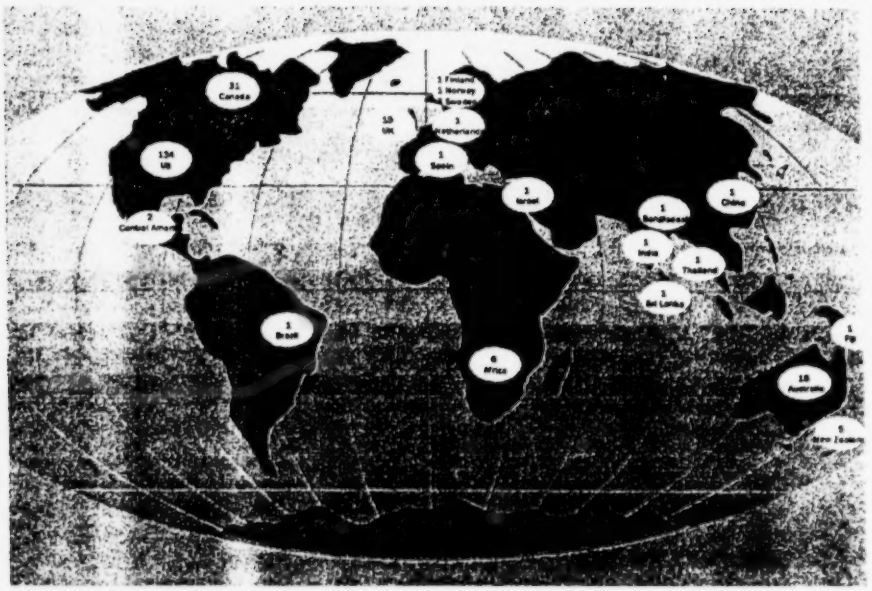



Figure 2: International community capacity projects represented in the research synthesis.

Primary funding sources for community capacity building projects were identified as part of the review process. Countries of origin for funders included Canada (11%), United States (50%), United Kingdom (11%), Australia (10%) and other (18%). Across these international funding bodies there was an equal allocation of governmental (50%) and non-govemmental (50%) funding for all countries listed above, with the exception of Australia where 73% of projects received governmental funding and 27% non-governmental funding. Levels of governmental funding included:

| | |
|---|---|
| National/Federal Funding | 58% |
| Regional/Provincial/State Funding | 13% |
| Local/County/Municipal/Township Funding | 22% |
| International Development Agency Funding | 5% |
| Other | 1% |

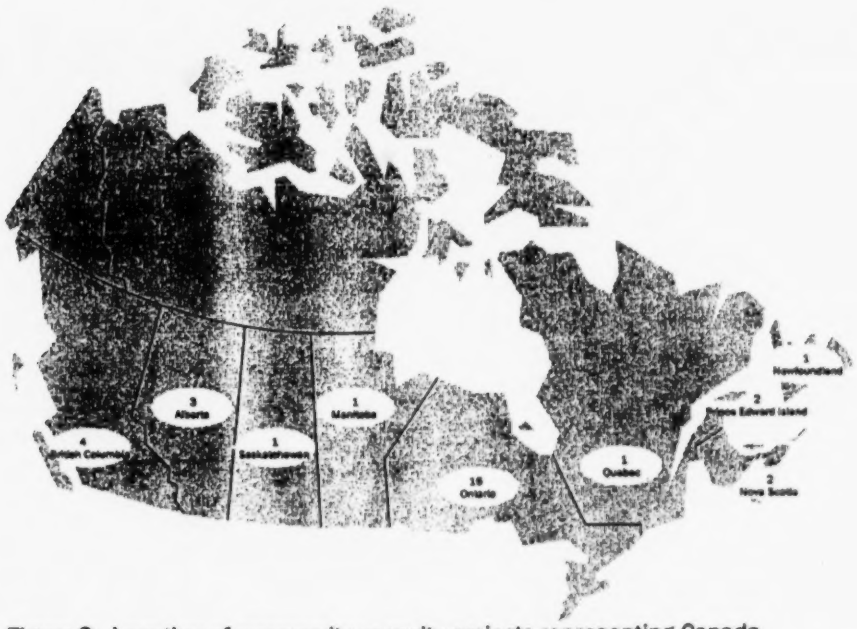
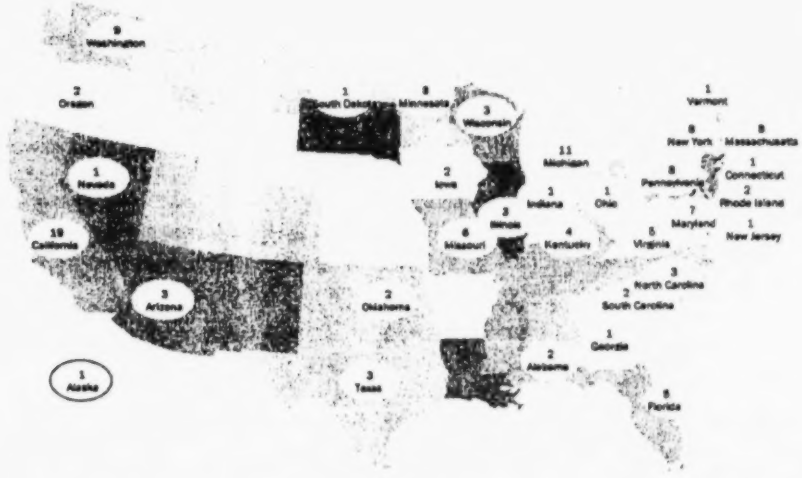



Figure 3: Location of community capacity projects representing Canada.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Levels of non-governmental funding included:

| | |
|---|---|
| Private Foundation | 20% |
| Educational Institution | 18% |
| Regional or Local Community Agency | 16% |
| Hospital or Medical Centre | 13% |
| Private International Development Agency | 12% |
| National Level Agency | 8% |
| Professional Association | 5% |
| Industry (e.g., Pharmaceutical Co.) | 4% |
| Other | 4% |

## Target Populations

Target populations of research synthesis projects varied and included children/youth/teens (31%), adults (16%) and seniors (8%). Forty-six percent of articles and reports analyzed did not specify a target population (Figure 5). Within the children/youth/teens category, 14% of projects focused on early years (0-6 years), 16% on youth/children (7-12 years) and 19% on teens (13-18 years). Fifty-two percent of the projects worked with multiple categories of children and youth spanning the various categories.

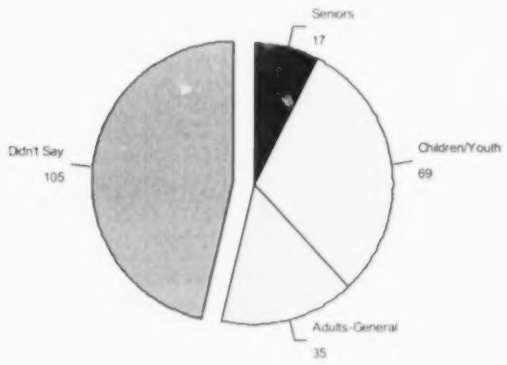


Figure 5: Number of community capacity projects by target populations.

## Geographical Boundaries of Projects & Sector Foci

Geographical boundaries identified by research synthesis projects included the following:

| | |
|---|---|
| Multi-site | 24% |
| Whole cities or towns | 20% |
| Service-defined catchment areas | 9% |
| Neighbourhoods or discrete census tracts | 9% |
| Regions (i.e., multiple contiguous counties) | 8% |
| Single counties, townships or districts | 8% |
| Multiple areas within cities | 7% |
| Housing developments or apartment complexes | 6% |
| Provinces, states or territories | 4% |
| Church congregations or church communities | 2% |
| Other | 3% |

Sector foci included:

| | |
|---|---|
| Health (e.g., health promotion; prevention; community health) | 83% |
| Human & Social Services (e.g., housing; poverty; crime; safety) | 5% |
| Education (e.g., literacy; education programs; etc.) | 2% |
| Arts & Culture (e.g., cultural programs; arts councils; museums) | 0% |
| Environment (e.g., transportation; environmental issues; etc.) | 0% |
| Multi-sector or combined focus | 10% |

Project foci included:

| | |
|---|---|
| At-risk women & children (e.g. homeless; abused; medically at-risk) | 23% |
| Immigrants/specific ethnic/cultural groups (e.g., recently immigrated Punjabi women; Vietnamese; African-American fathers; Korean Americans; Yakama Indians & other Native Americans;; Latina women; etc.) | 19% |
| High school students | 14% |

| | |
|---|---|
| Elementary/public school students | 10% |
| Economically disadvantaged | 9% |
| Individuals with mental health problems | 5% |
| Intergenerational program participants | 3% |
| Rural elderly/rural women | 2% |
| People living with HIV/AIDS | 2% |
| Smoking Cessation | 2% |
| Users of seniors' programs | 1% |
| At-risk pre-school students (e.g., high risk for lower literacy; economically disadvantaged; etc.) | 1% |
| Commercial sex workers | 1% |
| High school students with physical disabilities | 1% |
| Women with physical disabilities | 1% |
| Children with physical disabilities | 1% |
| Drug Users | 1% |
| Women with breast cancer | 1% |
| Lesbian, gay and bisexual youth | 1% |
| Young offenders | 1% |

Fifty-five percent of projects reviewed had been completed while 45% were in progress. Seventy-five projects reported a specific time frame for their work, while 25% of projects reviewed made no mention of any time frames. Duration of projects ranged from 6 months to 20 years:

| | |
|---|---|
| 6 months | 1% |
| 9 months | 2% |
| 1 year | 6% |
| 1½ years | 1% |
| 2 years | 14% |
| 2½ years | 3% |
| 3 years | 21% |
| 4 years | 5% |
| 5 years | 32% |
| 6 years | 5% |
| 7 years | 2% |
| 10 years | 6% |
| 11 years | 1% |

## Project Goals & Focus of Work with Communities

Project goals could be clustered into 4 major categories (Figure 6). More than half the projects reviewed (52%) identified their focus as health promotion and working to bring about health-related behavioural change, while 16% reported their goals specifically focused on building community capacity and community development.

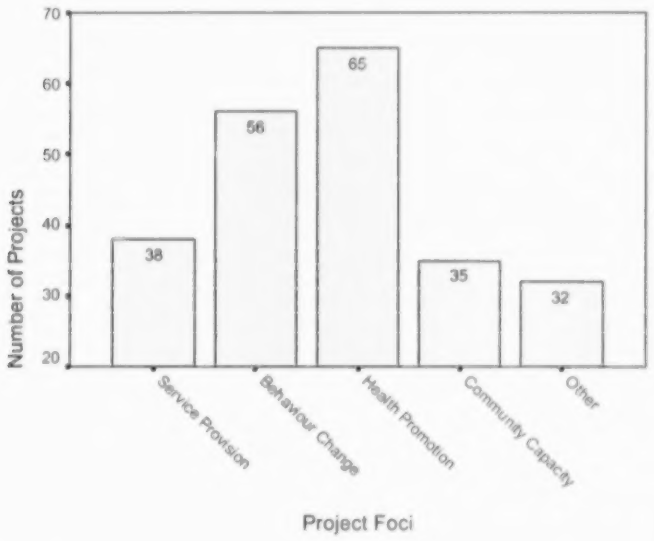


Figure 6: Overall focus of research synthesis project goals.

## Defining "Community"

For the purpose of the present community capacity research synthesis, "community" was defined as being more than a shared geographic area and referred to a collection of individuals living in a particular neighbourhood/area with an established network to address common or shared interests, where collaborative action is used to respond to both individual, as well as broader neighbourhood/community interests and needs. Inherent in this definition is the notion of citizens caring about one another and working on individual, as well as common, concerns.[60,68,76] In reviewing and analyzing community capacity building projects we were interested in three specific issues: (1) if authors define what they

mean by "community"; (2) how "community" is defined; and (3) if project definitions were consistent with the accepted definition of "community" published by leading researchers in the area of community capacity building.

Interestingly, of the 226 community capacity building projects reviewed only 7% (15 projects) provided a definition of "community". Of these 15, only 3 provided citations for their chosen definitions. Of the 15 projects providing definitions 59% of definitions were consistent with the published and accepted definition of "community" defined above. With the remaining 41%, most often when differences were noted the authors did not include the idea of collaborative/cohesive action. Primary differences in definition include:

- no reference to collective or collaborative action
- geographic/socio-economic definition only
- definition given is only in terms of locations/facilities that could be used by the project
- focus on health promoters/providers (vs. community members/community) working within a geographic area
- no reference to a geographic boundary; members may not live in proximity

## Approaches Used in Working with Communities

Published literature and experience confirm that terms such as "community mobilization", "community development", "community capacity" and "community-based" programs are often operationalized in different ways in the literature and many times, incorrectly used interchangeably. These terms, in fact, have very distinctly meanings.[60,77,78] For example, Shiell and Hawe[60] argue "community development programs in their purest form start with no fixed agenda or health issue" (pg. 243). Inherent in community development are such concepts as self-determined and driven action by a community (vs. professionally determined action), the notion of empowerment and transferring of control, voluntary collective action to produce change, capacity building, broad-based action that strengthens the community as a whole; it is a process that, in general, that improves the quality of life in one's community.[60, 61, 62,66,77] Community mobilization is typically viewed as falling under the "umbrella" of the broader concept of community development. While community mobilization shares many similarities with the concept of community development (i.e., a process that is community-driven and sustained, relies heavily on the concept of empowerment, leads to a better community, etc.), the fundamental difference is that with community mobilization an issue is *introduced* to a community (possibly from external sources) and then the community building process begins. A community is

mobilized around a particular issue (Figure 7). Community mobilization or action typically involves introducing a particular project or issue of interest to a community, determining the degree of willingness of the community to become involved, collaboratively establishing mutual goals, fostering and gaining community-wide, long-term commitment, collectively identifying issues of importance, community strengths, barriers, challenges and possible solutions, the community assuming ownership of previously identified and evolving issues and the formation of a solid community base from which future action is generated.[79,80,81,82] Community capacity refers to the ability of the community to harness it's skills, knowledge and resources to collectively work with the formal health system to determine action around community-identified health issues. Community capacity implies a shift in "power" from the traditional "top-down" approach (health system/professional driven approach), equal and shared decision-making, negotiating and problem-solving between all partners (i.e., community and formal health system). It also implies *long-term* community management of community-identified issues.

The community-systems approach[65] (Figure 8) is similar to these other approaches, however this approach differs from the others in that it also includes all levels of stakeholders or community partners (e.g., funders; planners; service providers; local communities) from the onset as *equal* partners, sharing decision-making around health issues. Integral to the community systems approach is the willingness and ability to be innovative with available community and system resources, and to make better use of what already exists (rather than adding new resources) by linking all partners in the planned change process. This approach is particularly useful for the health sector. The benefit of this approach is that by working collaboratively and sharing decisions from project inception, many potential future barriers are identified and resolved early on in the process without impacting, or compromising the sustainability of the project at a later date.

Community-based programming or service provision, on the other hand, is an entirely different concept that is externally driven, individually-focused, with specific services being provided (based on professionally-identified need) in community settings.[77] Community-based programs or services are typically determined, planned, implemented, evaluated and run by health professionals. The differences in the approaches can be seen in Figure 9.

Thus, in the present research synthesis is was deemed important to analyze the approaches used, and definitions of approaches provided, by community capacity building projects published in the literature.

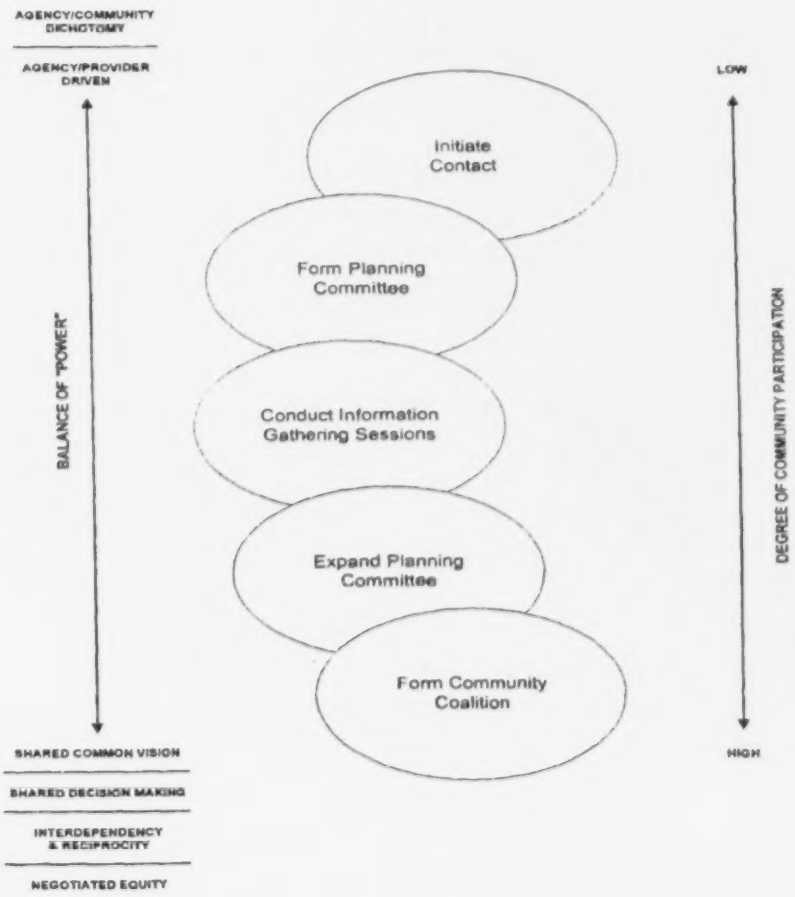


Figure 7: Key components and processes of community mobilization. Modified from: "The Path to Community Action" framework.[80]

Build & strengthen community resources.
Community skill development. Increase information & knowledge
COMMUNITY
(capacity-building)
EMERGENT/INTERACTIVE PROCESS
COLLABORATIVELY PLANNED/GUIDED CHANGE
CHANGE THROUGH CREATIVE THINKING & VOLUNTARY COMMITMENT BY CITIZENS & SERVICE PROVIDERS/AGENCIES
SYSTEM
(new care practices, new models of service delivery, policy change)
Improve planning, implemention, delivery & evaluation of services; improve resource utilization
HEALTHIER COMMUNITY
SELF-SUSTAINING MODEL

Figure 8: The community-systems approach.

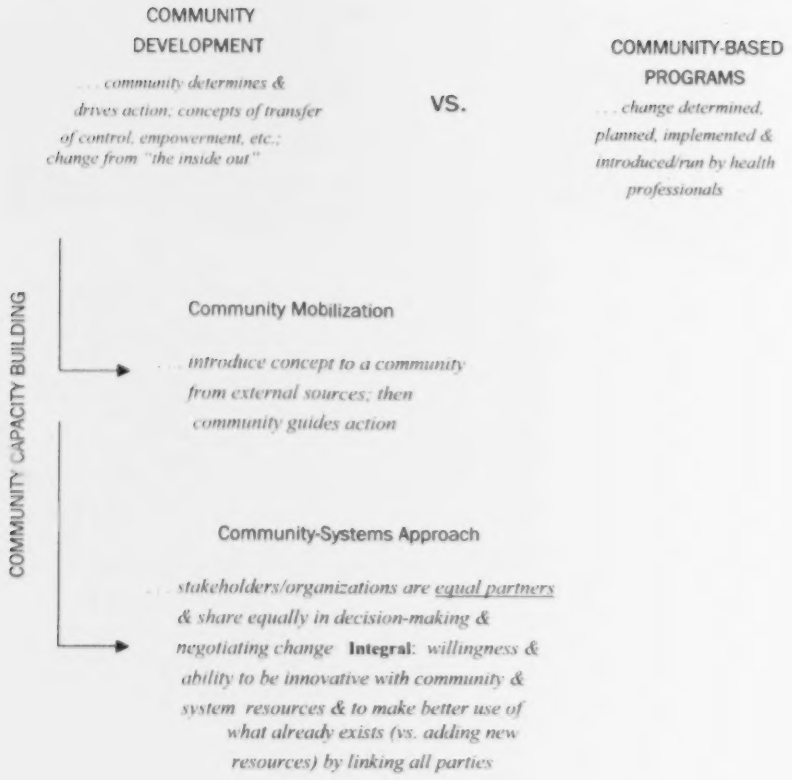
COMMUNITY
DEVELOPMENT
. . . community determines & drives action; concepts of transfer of control, empowerment, etc.; change from "the inside out"
VS.
COMMUNITY-BASED
PROGRAMS
. . . change determined, planned, implemented & introduced/run by health professionals
COMMUNITY CAPACITY BUILDING
Community Mobilization
. . . introduce concept to a community from external sources; then community guides action
Community-Systems Approach
. . . stakeholders/organizations are equal partners & share equally in decision-making & negotiating change Integral: willingness & ability to be innovative with community & system resources & to make better use of what already exists (vs. adding new resources) by linking all parties

Figure 9: Differences between the various approaches to working with communities.

All community capacity research synthesis projects were analyzed by the research assistant to determine the approaches used in working with communities. All projects were categorized using the standardized definitions outlined in the literature:

- community development
- community action/community mobilization
- community-systems approach
- community capacity building
- community-based programming

Two categories "insufficient information provided" and "other approach" were added if a clear determination could not be made. Of the 226 projects reviewed, more than a third used a community-based, professionally-driven approach with limited community involvement. Categorization of the approach was done by the research assistant by comparing the project description/activities outlined in the article/report with the standardized definitions.

| RESEARCHER-CATEGORIZED APPROACHES | % OF PROJECTS (N=226) | NO. OF PROJECTS (N=226) |
|---|---|---|
| Community development | 8% | 18 |
| Community action/mobilization | 19% | 42 |
| Community-systems approach | 17% | 38 |
| Community capacity building | 9% | 21 |
| Community-based programming | 36% | 81 |
| Insufficient information provided | 3% | 7 |
| Other approaches | 8% | 19 |

The 19 other approaches included:

Participatory action research (2 projects)
Community coalition building (2 projects)
Organizational capacity building (4 projects)
Community participation (5 projects)
Community development except that the community had to agree to address immunization as the 1st priority in order to receive funding (1 project)
Community consultation (3 projects)
Education model (2 projects)

In addition to the research assistant categorizing projects based on standardized and accepted definitions, all articles were analyzed to determine if specific definitions were provided by authors, and if so, what the authors' definition was.

In 60% of the 226 projects reviewed, authors provided a specific definition or description of approaches employed (or approaches they wished to use or felt that they had used) in undertaking their community project. The authors' definitions were extracted verbatim from the article or report and as such represent the authors' own viewpoint and working definition of the approach used. It is important to note that the definition provided by the authors was not influenced by the categorization process or by the research assistant in any way. Of the 60% of projects providing definitions outlining their approach, almost half (48%) provided definitions consistent with standardized definitions:

| AUTHOR-IDENTIFIED PPROACHES | % OF PROJECTS (N=135) | NO. OF PROJECTS (N=135) |
|---|---|---|
| Community development | 10% | 13 |
| Community action/mobilization | 21% | 29 |
| Community-systems approach | 9% | 12 |
| Community capacity building | 8% | 11 |

The remaining 52% of definitions provided by authors, while somewhat similar in their intention in how to work with community members, varied significantly in language and terminology used:

| | | |
|---|---|---|
| Participatory action research | 15% | (20 projects) |
| Community intervention model | 1% | (1 projects) |
| Consultation & education | 3% | (4 projects) |
| Management by objectives approach | 2% | (2 projects) |
| Community organization model | 7% | (10 projects) |
| Social/environmental approaches | 4% | (6 projects) |
| Health promotion approach | 7% | (9 projects) |
| Other approaches | 13% | (18 projects) |

The following provides an example of authors definitions from the "other" category"

## Examples of authors' definitions of approach for community capacity building projects

*"to go out into the community, to network and gain the trust of local people & professionals working in the area; listening to, and validating people's own life experience"*

*"COPE (client oriented/provider efficient) continuous quality improvement model"*

*"linkage approach; transfer of knowledge/skills/practice to user groups to assist with their tasks"*

*"church-based model incorporating features from a prevention model; information, affective, education, social competencies and alternatives"*

*"as per federal guidelines - community participation - family centred and culturally competent approach that will strengthen maternal and infant care systems — grantee must organize a consortium"*

*"dissemination model based on interaction and communication between producers and users of innovation:*

*"a partnership which co-ordinates the interventions across a number of settings and thus provides opportunities for the creation of health promoting environments in many areas of people's lives"*

*"community participation approach in which common ground is searched for between multiple different interest groups; many voices are welcome in the process"*

When the community organization model was mentioned it was most often accompanied by the references Bracht 1990[83], Bracht et. al., 1999[84], Minkler et. al., 1990[85], Hanna and Robinson, 1994[86], and Zandler, 1990.[87]

## Level of Involvement by the Community

There are clearly defined levels of community involvement, participation and/or engagement which must be considered when working on community capacity-related projects. Hierarchical levels of involvement outlined in the published literature include: (1) providing information and (2) providing education, both of which include a "top-down" flow of information; (3) consultation, which consists of a 2-way flow of information; and (4) active participation and (5) "true" empowerment, both of which involve the community in an ongoing fashion in planning and decision-making, and transfer "power" and control from health professionals and health agencies to the community.

Community involvement is an integral component of the capacity building process. For capacity building to occur, community members and communities must have active participation and "true" empowerment. This means that the community shares in decision-making, and in planning, implementing and evaluating programs and services. Community members should hold a majority of seats on committees, with delegated powers to make decisions. It implies a transfer of power and control to the community with evidence that the community and/or community members eventually "own" and operate some of the programs, as mutually agreed upon by both the community and health system. Health professionals providing information, education and consultation opportunities to communities/community members, in isolation of ongoing active participation and community power to "veto" decisions, is not community capacity building.

Of the projects included in the community capacity research synthesis (n=226) almost half did not outline a process that encouraged the active participation and "true" empowerment, the foundation of the community capacity building process (Figure 10). The following outlines the approaches reported by project authors:

Figure 10: Hierarchical levels of community involvement.

| Level of Community Involvement | % of Projects |
|---|---|
| Providing information | 4% |
| Providing education | 17% |
| Consultation | 22% |
| Active participation | 35% |
| "True" empowerment | 16% |
| Insufficient information provided | 6% |

Projects which involved the community at the "active participation" and "true empowerment" levels 51% (n=116) provided the following examples of specific activities to demonstrate their communities' higher level of engagement:

Table 6: Community capacity building activities reported by projects.

EXAMPLES OF SPECIFIC ACTIVITIES USED TO BUILD COMMUNITY CAPACITY

| Specific Community Capacity Building Activities | % of Projects (n=116) |
|---|---|
| ▫ community/neighbourhood-driven action/task teams | 32% |
| ▫ create coalition/board/transitions teams with broad-based representation including community representatives & leaders | 31% |
| ▫ training (and occasionally hiring) community residents to lead the information gathering process, conduct needs assessments, become health promoters & advocates for eldery individuals in their communities, & lead policy change efforts | 12% |
| ▫ support, training & leadership development re: grant writing, evaluation, effective communication, the policy process, etc. | 11% |
| ▫ community members assist with the running of specific programs | 5% |
| ▫ provide community with funding/budget (control over funding) with the expectation that they hire own staff & plan & implement programs of their choosing to meet mobiization goals | 3% |
| ▫ neighbourhood meetings/neighbourhood visioning process | 2% |
| ▫ networking among agencies, groups & community members to build a system of linkages | 2% |
| ▫ community members as research associates to work with & advise program staff & disseminate findings | 1% |
| ▫ information provided to the community with a mechanism for feedback | 1% |

Of the community capacity projects selected for full review (n=226) only slightly more than half (53%) actively engaged or empowered the communities with which they worked, although their publication titles and abstracts contained the "right" language (Table 5; page 26) that suggested community capacity building or community development initiatives were occurring. At this point we eliminated those projects that did not meet our criteria for true community capacity building (47%; n=107) and focused more closely on studies meeting these criteria (53%; n=116). We also included 3 projects for which there was insufficient information to determine whether they were community capacity building projects or not, for a total sample of 119 projects which we examined much more closely in terms of their conceptual and theoretical frameworks, collaborative governance structures, evaluation frameworks, major obstacles encountered and any new innovative strategies. The findings of these analyses are outlined in the following sections.

## Theoretical Frameworks

Of particular interest to the research synthesis project was whether community capacity building projects were grounded in, or driven by, a solid conceptual and/or theoretical framework.

Of the community capacity projects analyzed in much greater detail (n=119) almost half (48%; n=57) did not report any conceptual or theoretical frameworks that were used to guide the work with communities. Fifteen percent (n=18) of projects made some attempt to outline a conceptual framework but their approach, and/or the theories employed, were not clear. Only 36% (n=43) reported specific theoretical frameworks or major theories upon which they based their work. Furthermore, of the 43 projects that did mention specific theoretical frameworks, a third (33%; n=14), in describing their project, outlined processes that were not consistent with the theory initially selected to guide the project. The most common findings were (1) the role of the community was consistently unclear, (2) community involvement in decision-making was extremely limited, usually restricted to communities defined as professional "health care workers" and (3) theories were usually only cited/referenced, the relevance of the theory to a particular situation, and the application of the theory was routinely not explained. Theories identified are outlined in Table 7.

Table 7: Theories (and other evidence) identified by published community capacity building projects.

- coalition building
- community systems change
- social learning theory/social cognitive theory
- Paulo Friere's theories of community empowerment
- microenvironmental change
- concepts of activated status to define capacity in terms of a community committee's ability
- community-in-health empowerment model
- environmental theory (changes in social & structural contexts to alter individual behaviour
- community empowerment theory
- functional community organizing
- systems theory
- community participation & organization
- organizational development theory
- community development & health promotion continuum
- feminist process
- participatory action research
- resource mobilization theory
- problem behaviour theory & interaction of social environment
- community efficacy theory
- transtheoretical model of change
- causal model re: alcohol access, outlet utilization & consumption patterns
- adult learning theory
- Epstein's framework for planning & program development
- Vicker's concept of an appreciative system
- community development
- deterrence theory
- coalition theory
- social capital theory
- community development model
- social disorganization model of crime

Table 7: cont'd

- model of community participation & perceived ownership
- Kettner's 10 steps to community change
- stage theory of innovation
- community participation theories
- dissemination theory
- self-care theory of nursing
- program development/community practice theory
- community acceptance & role of key opinion leaders
- empowerment education model
- concept of learning organizations
- model of behavioural change
- Blum's model of health
- community resilience
- community capacity building
- incorporation of change model
- diffusion of innovation model
- empowerment as social action
- self-efficacy theory

These findings suggest there are many issues that need to be addressed and examined further to ensure a solid evidence-base from which to carry out community capacity building initiatives related to health.

A common criticism is that therapeutic interventions, health programs and services (and in this case health-related community capacity building initiatives) are planned and implemented without theoretical frameworks to guide them. Thus the question becomes:

*"If you don't understand the problem, how can you fix it?"*

Theory is "the construction of explicit explanations in accounting for empirical findings".[88] Theory "helps make sense of what we observe, helps explain how and why things occur, helps us predict behaviour under different circumstances and situations, is used to build knowledge and understanding in a systematic and

cumulative way, and is used to guide future research".[89] Theory is an important and under utilized base of knowledge that provides insight, guides professional practice, health programs and services, and provides information on what works best in different situations.

## Governance Structures & Community Representation

One can envision a hierarchy of governance structures for projects entailing collaborative operations between the community and health system, ranging from a true collaborative arrangement with a central accountability structure, through a coalition with individual agency accountability, to a single committee structure without central governance. The community can be involved to a varying degree at any level in any model.

Although many projects describe their governance structure in some way, there is a wide range of terminology from which the precise function cannot be inferred. Terms used include coalition, board, transition team, action groups, leadership board or team, community boards, steering committee, neighbourhood collaborative, community advisory boards, inter-agency tenant committee, management committee, wellness councils . . . and so on. Rarely is it possible to infer an operational model from the terms, or how the community is involved. We sought evidence of the latter in descriptions given within the reports and this was possible to a variable degree. For some high activity in the community was presented, while for others representation was suggested but no details were provided.

## Evaluation Frameworks

As anticipated, the evaluation-related questions were quite revealing. There appear to be many challenges with evaluation of community capacity building projects, the development of evaluation frameworks prior to project inception, and in establishing pre-determined timelines for evaluation. Of the 119 projects analyzed 41% (n=49) provided no information whatsoever, or just a passing comment, regarding the evaluation or success of their projects. While specific outcome indicators were mentioned in 75 projects (65%), in only 44 (59%) of these projects were evaluation indicators specifically relevant to the project goals established. Overall (1) project goals were rarely discussed in an evaluation context, (2) there was little or no evaluation of community participation or the outcome of community involvement, (3) project goals are so broad that measurement becomes a challenge, and (4) the evaluation process only addressed those goals most easily

measured (i.e., at the individual level) not those related to community engagement or capacity building. In many cases success of the project is based on anecdotal statements by authors or project staff only. Furthermore in many cases (71% of projects; n=85) there were no *pre-determined time lines* for evaluation built into the initial project design.

A further challenge is the level of evaluation or unit of analysis. Community capacity building requires collaborative work at the *collective* community level thus the most important evaluation outcome indicators should focus on the collective capacity of the community, and/or the collective community-systems level. Typical levels of evaluation/units of analysis, for community capacity building projects, should include[90,91]:

1. *Individual Level* (i.e., a change in knowledge, skills and/or voluntary involvement by individual community members, service providers and other non-professionals; change at the individual level)
    - □ change in community member/program recipient *function*
    - □ change in community member /program recipient *knowledge & skills*
    - □ change in community member/program recipient *involvement*
    - □ change in service provider *knowledge & skills*
    - □ change in service provider *involvement*
    - □ change in service provider *delivery of care*
    - □ change in other non-health professional *knowledge & skills*
    - □ change in other non-health professional *involvement*
    - □ change in other non-health professional *service provision*

2. *Collective Community Level* (i.e., the collective capacity of the community to identify issues and mobilize the resources necessary to bring about the desired change)

3. *Community Systems Level* (i.e., the ability of the "enabled" community to work together with the formal health system; ability to mobilize internal and external resources)

Of the 119 community capacity projects analyzed 98% (n=116) did not measure "community capacity", 99% (n=118) did not use any type of standardized tools to measure or evaluate the outcomes of their projects, and in 71% (n=85) of the projects no *pre-determined timelines for evaluation* were built into the initial project design. In terms of the levels of evaluation (community systems level, collective community level and individual level):

a. *Community Systems Level:* 99% of community capacity building projects (n=118) did not evaluate the ability of the community and health system to work collaboratively (only 1 project specifically addressed this)

b. *Collective Community Level:* 70% of community capacity building projects (n=83) did not evaluate or measure outcomes at the *collective* community level; while 30% (n=36) of projects did attempt to address this by using the following outcome indicators, many of the indicators (*) still do not capture or measure the collective ability of the community to work together to bring about change:

- ratings of community vs. external control
- amount of perceived co-operation and working together in the neighbourhood
- no. of peers involved in program planning*
- time spent on project (community vs. staff)*
- community members' perception of no. of factors in the community that were improved*
- no. of community leaders and volunteers involved in programs
- creation of a "system change" plan (there was no indication as to whether this was successful)
- degree of success re: support and resources*
- reported influence of coalition in policy change
- project model comparison (proposed vs. actual)
- interviews with lay educators re: what worked and what did not
- retention of coalition members*
- community empowerment ratings
- improvements in community relationships*

c. *Individual Level:* If evaluation indicators were present, most used "individual" change indicators. Fifty-five percent (n=66) of the projects analyzed identified individual evaluation indicators. Of these, change was targeted in the following:

- change in *program recipient* function — 40% (n=48)
  - knowledge & skills — 26% (n=31)
  - involvement — 25% (n=30)

Examples of change/evaluation indicators used to measure success, taken from community capacity building projects analyzed included:

- type & level of involvement
- team composition
- an individual's perceived influence within the coalition
- level of an individual's helping skills (pre & post)
- rate of physical inactivity
- percent of immunizations (pre & post)
- number of telephone contacts
- number of clients served
- number of clients enrolled in program
- self-reported tobacco use
- number of booklets produced
- health insurance data
- rates of smoking (city-wide comparison)

Examples of change/evaluation indicators taken from projects analyzed continued:

- number of screening procedures performed
- number of crashes; number of fatal crashes
- documentation of number of programs, materials, location of programs & participation levels
- time & resources used to implement programs/project
- number of families recruited and retained
- number of resident "activists" over time
- program attendance & participation
- number of reported injuries
- number of responses to survey
- minutes of partnership meetings
- number of applications submitted
- number of children receiving services
- number of funded housing spaces
- number of programs/services planned & implemented
- knowledge, attitudes & behaviour (self-report)

"Community capacity is a concept, if ever, measured or evaluated. Of the 119 community capacity building projects analyzed 98% ... did not measure, or attempt to measure, community capacity

- training evaluations
- ratings of self-esteem & mastery of surroundings
- results of participant evaluations; program satisfaction ratings
- policy changes
- number of collaboratively funded community service/research projects
- improvements in research design
- behaviour & intent to change attitudes & beliefs (self-report)
- resident access to existing services; provision of new services
- quality of life profile results
- monthly logs of peer contacts (number & type)
- number of missed appointments
- cost of injuries to health care service
- use of community venues ( number of people calling & "hits" on website)
- mortality & morbidity statistics
- explain how program affected the lives of volunteers
- number of press clippings
- number of recommendations undertaken
- number of home visits performed
- degree of success re: support & resources

Specific examples of *"community level"* indicators included:

- creation of a "system change" plan
- perceived neighbourhood pride
- reported influence of coalition in policy change
- project model comparison (proposed vs. actual)
- community empowerment ratings

Only 1 project (n-119) reported using a standardized instrument to measure community capacity: *Flynn's Community Ownership Scale*[92]

Evaluation approaches and timeline (when reported) varied significantly. Eight projects analyzed conduced pre-post project comparisons. Other project resported a variety of evaluation timelines including baseline and 1-year (n=7), baseline and annually for 1-5 years (n=3), pre, post and follow-up (n=3), baseline information only (n=1), and baseline and 5 months (n=1).

There is clearly a significant problem in evaluating the success (or lack thereof) of community capacity building projects and this should be a critical area for consideration in the future.

## What Does the Evaluation Literature Tell Us?

Throughout the community capacity and evaluation "field" the term evaluation is used in a wide variety of ways. Although evaluation is usually defined as a process of measurement of performance and feedback to improve the program, and research more as a means of seeking new knowledge, hypothesis testing and so on, the demarcation is by no means distinct and both are required in the area of community capacity building. Thus evaluation can be the process whereby one can test the components to see if they are functioning ideally, or the program as a whole to see how it is operating (e.g. by one of a program logic model). The basic question of whether it works at all is fundamentally important but rarely addressed, in part because of the time involved. One study[93] showed how much effort can go into achieving very little. Other community development programs only begin to report outcomes after 10-15 years.

Although the purists protest that community capacity building is an end in itself and brings its own rewards, these remain to be demonstrated by more than anecdotal reports. The proponents of this viewpoint object that quantitative analysis misses many of these benefits. While this may be true we can reasonably ask, from the point of view of health, such as it would be of interest to Health Canada: *"What benefits have been known?"* Much evaluation explores process and activity in the community. Some seek to achieve a consensus on the processes of community capacity building by surveying the practitioners and their views. Some have tried to evaluate the skills of the participants that increase the chances of "success." We have attempted to categorize the areas of interest reflected in the literature in an attempt to give some structure to the field.

### 1. Skills Required for Successful Capacity Building

*Health Professionals/Practitioners*: There is a specific skill set that community capacity builders should have at their disposal, and which could be acquired by training:

- the ability to interact with "ordinary" people
- strategies to get community members to meetings
- strategies to identify leaders in the community
- strategies to identify community strengths & resources (e.g., asset mapping; etc.)
- strategies to identify sources of information/data in the community
- strategies to identify learning needs & teach community members what they need to know

Such a skill set is partly reflected in various toolboxes for community capacity building.[94]

*Community Members*: In order to participate meaningfully there is an identifiable set of skills the community members need, once again touched on by the authors. For example:

- education on the issue at hand, if it comes from the outside
- training re: how to run committee meetings
- training re: how to communicate with health professionals
- training re: how to access information, data, etc.

*Evaluators*: In order to evaluate community capacity building evaluators need a range of skills, and likely a certain disposition. For example:

- skills in how to work with "lay" public in a sharing manner (rather than an overbearing way)
- scientific knowledge of a wide variety evaluation and research methods and processes and demonstrated ability to apply a wide variety of these processes to community-related work
- knowledge of communities, information/data sources, health systems, funding opportunities, etc. in order to help guide the development of an evaluation process to produce outcomes relevant to all collaborative partners (i.e, funders, health agencies, community, system and community planners and policy-makers)

Each of these knowledge and skill sets could be expanded providing a basic guide to community capacity builders.

## 2. Evaluating the Process

Many professionals have attempted to identify parts of the process of community capacity building, components to put in place and a way to evaluate progress in process. Two main processes are identified in the literature: (a) preliminary readiness assessment; and (b) the steps in building community capacity to achieve the objectives.

a. *Pre-Project Assessment*: This assessment should identify the characteristics of the community and can include: (a) an environmental scan specific to the issue or issues (whether they be focused or the building of community capacity as a whole) relevant to the activity contemplated; this will include physical structures, services and organizations to be involved, relevance of the issue to the community; (b) demographic factors such as education and income, by-laws and other regulations, modifiability of relevant structures[95]; and (c) willingness of community to be involved (a concept which, itself needs expansion). An exploration of barriers and costs is important.[94]

*b. The Process of Building Community Capacity*: Several authors have attempted to produce a list of process goals and indicators that show the progress toward community capacity building. Mostly this has been done through consensus, or by surveying individual practitioners who seek their opinion, though we found no prospective study to evaluate the conclusions. Some have produced measuring tools to demonstrate the steps are being taken in evaluating partnerships[96], evaluating community ownership[97], measuring the degree of mobilization[98], building networks and collaborative structures, data gathering and so on.

Some authors do not separate out the preliminary evaluation from the on going process [99] but for funding purposes we believe it needs to be done; otherwise there is a risk of funding the un-doable. Once the process has been defined for the particular project, indicators are needed to demonstrate progress. Indicators are specific to the project and its objectives and may have been used. Frankish and his colleagues[100] identified over 6,600 indicators in a review of 117 projects. We have identified two main categories of progress indicators from the literature:

i. indicators that the process is on target; each critical component is linked to an indicator; for example the development of partnerships[96]

ii. indicators that the specific issue (if there is one) is being addressed[100]; some have talked of indicators of interim or surrogate objectives to satisfy the need for funders that something useful is likely to come out of the endeavor

We believe both items are needed as one can focus on the "how to" aspect of community actions without ascertaining whether outcomes are being achieved.[101] An evaluation framework to guide the measurement of identified indicators is needed. Some authors have attempted to provide guidance on how to establish an evaluation framework.[93,94,102,103,104,105] Firstly, health professionals need to decide on the methods (qualitative vs. quantitative) most appropriate for the measurement considered. It is likely that a mixture of both is required though some object to the use of quantitative methods. None the less these are likely needed for the funder. Secondly, underlying the whole process is the need for the investigators to decide upon a research paradigm.[106] Again no clear-cut evidence is available to guide choice but as suggested by the IDM Manual the traditional experimental design (top down research) is likely to be less appropriate than a collaborative process such as participatory action/research. The advantage of this is that it bridges the gap that frequently exists between research and practice. (see reference 107 for further discussion of this). Thirdly, within the conduct of the whole community capacity building process a model may be required to provide internal feedback about the progress being made and its appropriateness. For example, some have advocated some form of program logic model, quality improvement methodology[108], staged Goal Attainment Scaling (GAS)[109] as a way of operating that the community can understand and participate in. No evidence exists to guide the choice of one vs. any other in any given situation but as Ader[108] points out, it is difficult to employ quality assurance in the absence of standards of practice.

### 3. Demonstration of Outcomes

Outcomes relevant to the purpose of the endeavor need to be demonstrated. For the true capacity building process we have very little, if any, evidence of health outcomes being clearly shown. A major problem here is the time scale involved, as, depending upon the health issue and the lag between, for example, behavior change and benefit, it may be many years before benefit can be assessed. There is no evidence regarding the natural history of community development and its potential benefits. Thus it is conceivable that attempts to change the mores of a society regarding health behaviors could take a generation. It is well known in the field of adult education that knowledge can be increased without there being much change in well-ingrained behavior. Nonetheless, the investment in the methodology can be large and if the ultimate goal is sustainability then some success needs to be shown. Logical interim or surrogate outcomes may have to serve and should be agreed upon with funders before beginning. Even for simpler programs it is frequently found that little evaluation is done.[110,111]

### 4. Post-Project Sustainabilitly

Post-project sustainability is a critical consideration but the needed elements of sustainability are not much explored in the literature. It is generally accepted that

sustainability requires the project to be subsumed into the system and risks of this have been identified. For example, the danger is recognized that the culture of the institution assuming control of the project may not be in keeping with the philosophy of the initiative. The authors have, from their different work in geriatrics and childhood both seen this happen. We feel it is critical, as a project or initiative is being institutionalized, that the critical elements that ensured its success be identified, be incorporated into its future ongoing maintenance and that a post-institutionalization assessment be done to ensure that this is so.

## Major Barriers Encountered In the Community Capacity Building Process

There were many reported obstacles to the community capacity building process that compromised project implementation, growth and sustainability. These are outlined in Table 8. The following summarizes and classifies the identified barriers, and identifies what is needed:

Need to have the community "on-side"

- build trust; identify sources of distrust (e.g., negative past experiences) and resolve
- need funding for preliminary ground work
- shared vision
- agree on priorities

Need to have professionals working together

- shared vision
- common way forward with no competing agendas

Need to have professionals and the community working together

- need adequate community involvement
- shared decision-making and power
- appropriate attitudes of professionals to working with communities
- deal with the organizational/bureaucracy/accountability mis-match between community and health service providers
- know the limits of the community members

Need to provide the community with tools

- identify the knowledge and skills of community members, provide education, resources and support as required
- avoid over-burdening community members (e.g., asking too much of too few community members)
- provide education regarding the need for evaluation and its implications

Table 8: Obstacles and barriers to community capacity building process as reported by projects analyzed.

| Reported Community Capacity Building Obstacles & Barriers |
|---|
| ▫ lack of community trust |
| ▫ community skepticism |
| ▫ competing agency agendas, demands & motivations |
| ▫ issues of ownership & control; power imbalances |
| ▫ barriers to community member participation including<br>physical barriers<br>social and/or political barriers<br>frustration/impatience with process (vs. impulsivity & action)<br>cultural insensitivity & lack of cultural understanding,<br>level of community expertise/knowledge re: participation and/or collaboration |
| ▫ reliance on a core of active/knowledgeable pool of individuals which leads to issues of burnout, attendance, dependence upon their presence, etc. |
| ▫ research design difficulties (e.g, sample size; control issues; etc.) |
| ▫ evaluation & data collection difficulties (e.g., what to collect; how best to to collect the required information; lack of evaluation tools; etc.) |
| ▫ inadquate time & money; short-term funding for long-term goals |
| ▫ unstable project funding; project instability |
| ▫ difficulties related to funding structure or requirements (e.g., funder priorities driving the process vs. community driving the process) |
| ▫ difficulties in establishing clear goals/vision/definitions (e.g., shared visions with multiple, collaborative partners) |
| ▫ difficulty on the part of staff, professionals and organizations in altering their top-down, service-oriented approaches & related power-shifts |

Need to ensure researchers/funders/capacity builders are in agreement on many issues

- including objectives, evaluation indicators, time lines, need for preliminary ground work, interim program objectives

Need to identify the simple practical issues that can derail a project

- lack of transportation for community members
- lack of child care
- lack of free time

The key requirements are largely the mirror image of the obstacles identified. They largely highlight the need for good preliminary work, planning ***with*** the community including the evaluation process, obtaining involvement without overloading individuals, and an emphasis on the attitude and approach of professionals and their organization's willingness to share power and funds through a collaborative governance structure, and agreement and understanding on the part of the funder.

## Key Requirements for Community Capacity Building & Innovative Ideas

Synthesis research projects were analyzed to determine what worked well for others involved in community capacity building initiatives (Figure 11). The following examples were extracted from project articles and reports:

- community members must be actively involved from the beginning in identifying needs & services
- project teams must remain responsive & flexible to community needs
- discussion & planning must take place locally with people who feel the issues
- building on community concerns facilitates mobilization efforts
- services are directly accountable to the community they serve & the responsibility for services lies with the community; ownership, including financial/budgetary control, within the community leads to increased willingness to participate especially on the part of local businesses and media
- the university team maintained a purely collaborative/training approach while each community made all local decisions according to its own needs, using the information/resources provided by the research team
- a community capacity building approach must be TRULY bottom-up; power needs to shift so that community groups initiate their own projects & control their own funding
- health agencies need to develop their own organizational capacities to support community participation & development
- it is very important to understand the local cultural context; does not override existing social/political structures, but instead works within them; historical cultural contexts are of particular importance
- communities must have a certain degree of "readiness" to benefit from a community capacity building approach; already established groups provide a basis for growth; recruitment process is simplified due to pre-existing groups with similar focus in the community; results exceeded expectation because of the pre-existing interest and activity of communities; communities themselves elevated the priority of the project

- focus should be placed on the strengths of the groups rather than on needs
- focus on shared strengths discovered for themselves allows residents to develop a shared vision which crosses cultural boundaries
- inclusion of all generations, drawing on the wisdom of the elders to teach the youth helps coalitions succeed
- use lay home visitors to recruit community members to the coalitions
- open membership allows onoing recruitment according to needs/issues
- incorporate message into many general activities with low demand, low commitment approaches to increase participation
- a training retreat for community members is critical to program development
- the presence & involvement of children & youth helped to show a new generation another way to approach issues
- ongoing leadership development tailored to the situation as it evolves over time leads to emergence of sound leadership within the communities
- education provided to community members helped them to address other community issues on which they formed groups & took action
- it is critical that the grantee establishes commitment to shared power prior to the implementation of the project
- a formal collaborative governance structure increases accountability of all parties; important to have formal agreements re: budgetary & control structures of the partnership; control should "tip" in favour of the community
- the process, although time consuming, is necessary so that all partners can be involved in defining & adopting common principles
- use of a professional consultant to assist coalitions to complete the initial organizing & planning process moved the community & partners more quickly toward "doing something"
- issues of letting go of egos & agendas, accountability & flexibility are of great importantce and must be addressed on a regular basis
- professionals who are known to & trusted by the community assist in overcoming problems associated with trust & the establishment of roles
- it is important to have an ongoing evaluation process within & by the community to create a feedback loop to inform ongoing process initiatives
- must have stable core funding to employ a stable core of professionals to assist with training, administrative support and structure to community groups
- funders must be flexible to allow partnerships time to deal with matters of interal process & trust

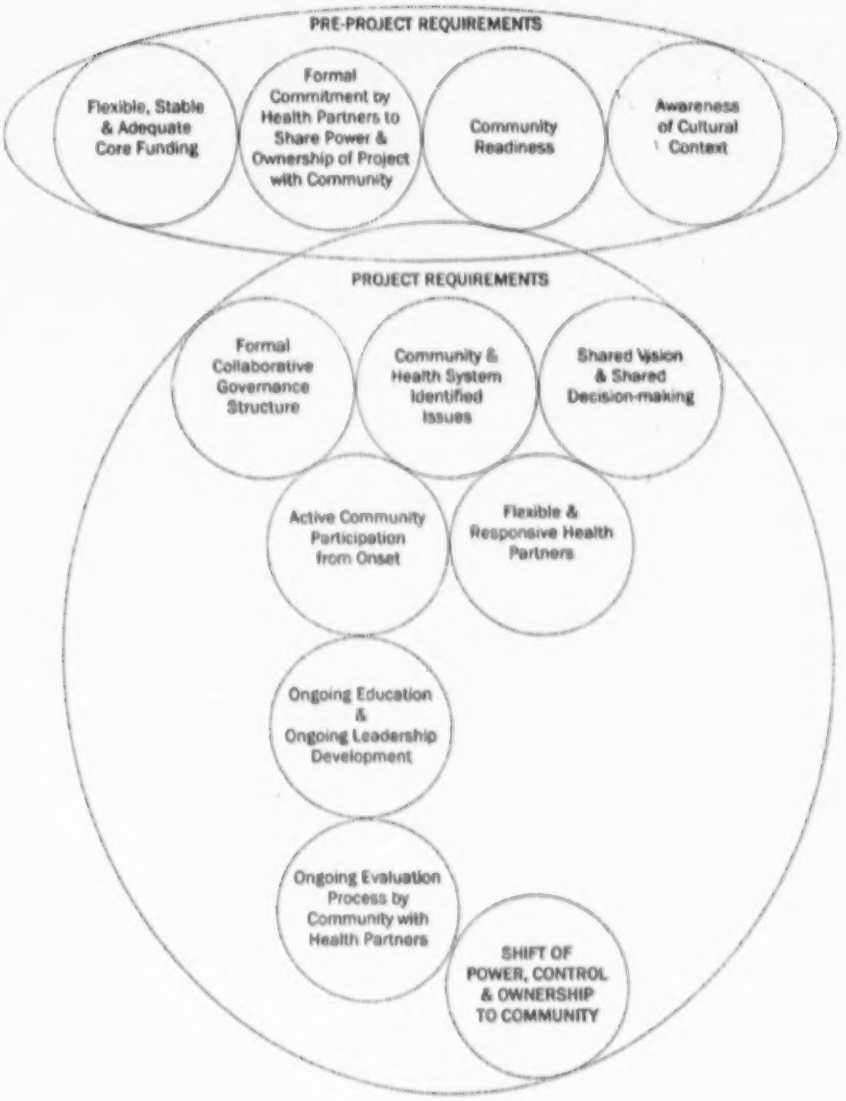
PRE-PROJECT REQUIREMENTS
Flexible, Stable & Adequate Core Funding
Formal Commitment by Health Partners to Share Power & Ownership of Project with Community
Community Readiness
Awareness of Cultural Context
PROJECT REQUIREMENTS
Formal Collaborative Governance Structure
Community & Health System Identified Issues
Shared Vision & Shared Decision-making
Active Community Participation from Onset
Flexible & Responsive Health Partners
Ongoing Education & Ongoing Leadership Development
Ongoing Evaluation Process by Community with Health Partners
SHIFT OF POWER, CONTROL & OWNERSHIP TO COMMUNITY

Figure 11: Thematic analysis of projects (n=119) identifying key requirements to facilitate community capacity building

# CHAPTER 5: CAPACITY THINK-TANK

## THE PURPOSE

The purpose of the Health Canada synthesis research "think-tank" was to bring together health professionals, researchers and others with experience in community capacity building related to health. Specifically the goals were twofold: (1) to gather, from the perspectives of health service providers, government policy-makers and community-based funders to information on issues related to community capacity building that need to be addressed, to identify and determine how to best integrate cross-sector community capacity issues, identify common themes, reach consensus on priority issues; and (2) to gather, from participants, a list of any community capacity building or community development projects they are aware of that can be contacted and included in the subsequent survey.

## THINK-TANK PARTICIPANTS

Think-tank participants included health service providers, funders and government policy makers. The following organizations were represented:

- Investing in Children, London, Ontario
- Division of Geriatric Medicine, University of Western Ontario
- United Way of London and Middlesex, Ontario
- Thames Valley District Health Council, Ontario
- Population and Community Health Unit, University of Western Ontario
- Ministry of Health, Long-Term Care Division, Ontario
- Community Services, City of London, Ontario
- London Inter-Community Health Centre
- Division of Childhood & Adolescence Centre for Healthy Human Development, Community Based Programs, Health Canada, Ottawa
- Office of the Voluntary Sector, Centre for Healthy Human Development, Health Canada, Ottawa
- United Way, Windsor, Ontario
- Population and Public Health Branch, Alberta/NWT Region, Health Canada
- London Community Foundation
- United Way, Ottawa
- Canadian Health Network, Centre for Healthy Human Development, Health Canada, Ottawa

## THE PROCESS

The day-long think-tank involved a 3-step process: (1) the morning was designed to provide think-tank participants with an overview of community capacity building and issues related to the seniors' perspective, the children's perspective and Health Canada synthesis research project goals, objectives and research questions; (2) this was followed by interactive group sessions to identify community capacity issues that are commonly dealt with, and need to be addressed, from the different perspectives of health service providers, government policy-makers and community-based funders with the various groups presenting the issues from their perspectives; and (3) the afternoon focused on finding common themes, reaching agreement regarding priority issues, moving from "thoughts to action" by deciding next steps and where we need to go from here.

## THINK-TANK FINDINGS

A summary of think tank finding is presented in Figure 12. It is important to recognize that the process will differ depending upon the nature of the project, whether it be community-based programming or "true" community capacity building. This will in part be dependent on clear language and definitions.

Engagement: Challenges identified ranged from figuring out who the community is, to identifying the right people to be involved while avoiding overloading the limited few community members who typically participate. Additionally it is recognized that simply having citizens on the committee does not signify collaboration nor true involvement. The community must be a part of the process, from the beginning, going beyond what would be called "representation" or consultation. The time the community has available to be involved will vary greatly. For some communities survival is a full-time occupation and a different process of engagement will be required. Identifying and distinguishing between community needs and community wants is essential.

Resources: Resources are critical but it is recognized that funding is easier when an agency or institution can be identified as the conduit for the funds and who will accept responsibility and accountability for the funds. Funding was seen as critical for several elements including the operating needs of the collaborative, the process requirements, as well as more basic research to build the evidence base for the community capacity field. A different model of funding is needed. Currently health systems exist in individual segments with a vertical funding and reporting/accountability structure ill-suited to these activities. The lack of an

COMMON VALUES, PHILOSOPHY & UNDERSTANDING OF THE CONCEPTS
. lack of consensus re: what community capacity building is; need standardized definitions of community, community capacity building, etc.
. must have a common understanding of the various perspectives (funders, policy makers, service providers, researchers, etc.) & the issues, needs & pressures each are faced with
. education toward a shared vision is required
. valuing the concept of community capacity building & getting commitment from all parties to true community involvement
. multiple projects & multiple funders but no interface
RESOURCES
. it is a challenge building & sustaining community capacity projects by "grant shopping"
. need separate funding stream designated for community capacity building & improved co-ordination of funding across sectors
. formal commitment to collaborate & adequate resources from all parties is critical
. adequate time, funding & flexibility is required to build community capacity
. majority of funding currently goes to institutions, while community health service provision is increasing; unequal balance of funding
. need funding to support sustainability of initiatives (beyond demonstration phase: the "critical window") & to develop community capacity tools
. adequate time is critical!
COMMUNITY/CITIZENS
HEALTH SYSTEM ISSUES
. it is a challenge working with government & institution "silos" issues of ownership & control present major challenges; capacity building requires different funding, governance & accountability requirements; must integrate, streamline & seek common ground (fear, mistrust & different agendas)
. necessary to pass control to community & between groups; unwillingness of institutions to share power (the infrastructure required before projects begin)
. institutions' lack of understanding of true "community development"; need paradigm change among service providers; capacity building is different from program development
. need government vision & policy to support community capacity building; current funding policies & reality of issues don't fit; funder & service provider mandates create barriers
HEALTH SYSTEM
COMMUNITY CAPACITY BUILDING
COMMUNITY BASED FUNDERS
COMMUNITY INVOLVEMENT
. communities must be an active part of the community capacity building process with shared & equal decision making; "a support letter doesn't signal collaboration; putting citizens on funding panels doesn't signify community input"
. must overcome the "top-down" tradition of community consultation
. broad-based representation is required; "engagement overload", same players all the time; communities should be encouraged to help each other
. define who "community" is (formal vs. informal)
. getting the right players to the table; knowing who to talk to
. leadership & facilitation is key & raises issues of power & control
. balance between community wants, actual problems & theory-based approaches
. community trust critical
GOVERNMENT/ POLICY MAKERS
EVALUATION, MEASUREMENT & IMPACT ANALYSIS
. community capacity building is hard to sell; must link to improved health outcomes in an evidence-based, high impact way
. must measure evolution from individual to community empowerment
. need adequate time & funding for evaluation & research; currently pressure to get things accomplished; time-intensive "up-front work not recognized; emphasis on results not process; measure performance & impact
. currently inappropriate outcome measures for project goals; need standardized & well defined community capacity building evaluation/measurement indicators
. must demonstrate value for money &disseminate findings across sectors (and within); knowledge transfer issues; need more than just reports
Communication was identified as being critical (funder to funder; funder to community; among all cross-sector partners); improved communication & communication processes are required

Figure 12: Cross-sector community capacity building issues, common themes and priorities identified during the January 2003 "think tank" hosted by the Division of Geriatric Medicine, University of Western Ontario, London, Ontario

COMMON VALUES, PHILOSOPHY & UNDERSTANDING OF THE CONCEPTS
lack of consensus re: what community capacity building is; need standardized definitions of community, community capacity building, etc.
must have a common understanding of the various perspectives (funders, policy makers, service providers, researchers, etc ) & the issues, needs & pressures each are faced with
education toward a shared vision is required
valuing the concept of community capacity building & getting commitment from all parties to true community involvement
multiple projects & multiple funders but no interface
RESOURCES
it is a challenge building & sustaining community capacity projects by "grant shopping"
need separate funding stream designated for community capacity building & improved co-ordination of funding across sectors
formal commitment to collaborate & adequate resources from all parties is critical
adequate time, funding & flexibility is required to build community capacity
majority of funding currently goes to institutions; while community health service provision is increasing; unequal balance of funding
need funding to support sustainability of initiatives (beyond demonstration phase: the "critical window") & to develop community capacity tools
adequate time is critical!
COMMUNITY/CITIZENS
HEALTH SYSTEM ISSUES
it is a challenge working with government & institution "silos" issues of ownership & control present major challenges; capacity building requires different funding, governance & accountability requirements; must integrate, streamline & seek common ground (fear, mistrust & different agendas)
necessary to pass control to community & between groups; unwillingness of institutions to share power (five infrastructure requirements before projects begin)
institutions' lack of understanding of true "community development"; need paradigm change among service providers; capacity building is different from program development
need government vision & policy to support community capacity building; current funding policies & reality of issues don't fit; funder & service provider mandates create barriers
HEALTH SYSTEM
COMMUNITY CAPACITY BUILDING
COMMUNITY BASED FUNDERS
COMMUNITY INVOLVEMENT
communities must be an active part of the community capacity building process with shared & equal decision making; "a support letter doesn't signal collaboration; putting citizens on funding panels doesn't signify community input"
must overcome the "top-down" tradition of community consultation
broad-based representation is required; "engagement overload", same players all the time; communities should be encouraged to help each other
define who "community" is (formal vs. informal)
getting the right players to the table; knowing who to talk to
leadership & facilitation is key & raises issues of power & control
balance between community wants, actual problems & theory-based approaches
community trust critical
GOVERNMENT/ POLICY MAKERS
EVALUATION, MEASUREMENT & IMPACT ANALYSIS
community capacity building is hard to sell; must link to improved health outcomes in an evidence-based, high impact way
must measure evolution from individual to community empowerment
need adequate time & funding for evaluation & research; currently pressure to get things accomplished; time-intensive "up-front work not recognized; emphasis on results not process, measure performance & impact
currently inappropriate outcome measures for project goals; need standardized & well defined community capacity building evaluation/measurement indicators
must demonstrate value for money &disseminate findings across sectors (and within); knowledge transfer issues; need more than just reports
Communication was identified as being critical (funder to funder; funder to community; among all cross-sector partners); improved communication & communication processes are required

Figure 12: Cross-sector community capacity building issues, common themes and priorities identified during the January 2003 "think tank" hosted by the Division of Geriatric Medicine, University of Western Ontario, London, Ontario

evidence-base is also an obstacle to getting funding as is the protracted time line for most projects. The funding cycle and duration of grants is too short for this work and the outcomes take too long to satisfy the reporting requirements of most funders. Short duration of funding hampers attempts to achieve sustainability. Indeed project leaders may spend much time piecing together short-term grants to keep the project going over the longer term. This capacity building "grant shopping" is not feasible and impacts sustainability. It is suggested that community capacity building be a recognized way of doing business in health, and that a separate funding stream be identified for this. Projects should contain a plan for sustainability beyond the demonstration phase, but a balance needs to be struck between "too-early" termination and endless demonstration.

Impact: Many issues were brought up around the measurement of process and outcomes. Several key issues were identified:

1. The need to identify interim outcome measures to satisfy the funder that progress is being made; these indicators must be identified up-front with the funder.

2. There needs to be a clearly defined and standardized process for measuring the growth in community capacity.

3. The need for funders to recognize the sometimes protracted start-up time, the time it takes to build collaborative relationships and that the appropriate determination of process and outcomes cannot be hurried.

4. The demonstration of value for money is inevitably dependent upon the value system of the funder and the recipients; the lack of a standardized set of indicators reflects the "looseness" of the field.

5. There needs to be a logical link between the indicators and the longer term outcome goals; this can best be achieved if there is a theoretical framework underlying the project and directing both goals and processes such that performance or process measurements logically lead to the outcome measurements.

6. A process for the sharing of experiences would help; knowledge transfer is critical and is not served by reports to funders that don't get circulated; a system of reporting and sharing will help until the evidence base is built and more formal processes can be put in place.

Philosophy & Value System: The concerns here stretched from the fact that funding policies and the reality of community capacity building don't fit; the interaction of the work, proceeding over a longer period of time, and the political process -- competition of dollars, need to show quick results and need to get intermittently re-elected -- can be problematic; in the field flexibility is critical but can be hampered by the need to be accountable to the funder for doing what was promised in the proposal; amongst the workers, ideological issues can be a problem; it was suggested that a paradigm change among service providers – essentially "fixers" with a top-down view of work – is needed; as with accountability to project funders, accountability to agency or institution managers can be problematic if the value of the community approach is not recognized; within the community the passive "do-for-me" attitude can be problematic; also the lack of experience around processes, the lack of insight into the health system and how it operates can turn people away. Overall it was felt that community capacity building required not just work on the knowledge, skills and involvement of the community, but also work on the rules, processes and attitudes of the health system.

Evaluation: The challenge is to come up with a framework that will meet the needs of the funders (short-term and political imperatives), the project itself (long-term outcomes perhaps taking years) while recognizing the difficulties of conducting research in a community environment where the needs of the community and the needs of the researchers may not be compatible. Agreement on measurement indicators and how to collect them is required. A significant issue is the lack of an established methodology for evaluation of capacity building. The standard medical randomized controlled trial (RCT) model is inappropriate. Academically and scientifically acceptable standards for community capacity building need to be established.

# CHAPTER 6: COMMUNITY CAPACITY BUILDING PROJECT SURVEY

Through information obtained directly from the following sources a total of 208 projects were identified:

- health professionals (by survey)
- participants at the capacity building think tank (see Chapter 5)
- projects with which the authors had prior knowledge
- projects identified during the literature review
- reports available to us
- funders web-sites
- and other contacts

The project survey consisted of both open- and closed-ended questions (see Appendix C), and designed to obtain information both on the projects themselves, and the information or resources the project staff would have found of value. The survey was pilot tested with 2 local projects similar to those selected for inclusion in the survey. The results of the pilot test were positive. No revisions were recommended.

Of the 208 surveys, 159 were sent by e-mail. /the remaining 49 where no e-mail address was provided were sent by standard mail (Canada Post). Despite follow-up twice by telephone and e-mail a poor response was obtained, with only 19 completed surveys being returned. On telephone follow-up most responded that they had no time to complete the survey, that they felt their project was not a good fit, or that funding was their priority at the moment. Some felt the time lines for completion (4 weeks) were too short, and in several cases staff were temporarily taken from their annual jobs to help with the unexpected SARS outbreak. The following analysis is, therefore, based on a small sample (n=19). Although the results need to be received with caution, some useful information was obtained and results were consistent with our literature survey findings and our own personal experience.

Respondents were asked to provide comments on different aspects of the community capacity building process as they had experienced it, and what would have helped them. They were then specifically asked if guidelines in certain areas would have been helpful. The following is a summary of project survey findings.

1. Community Involvement

The projects who responded to the survey represented a wide variety of activities involving a wide variety of communities. There were also a variety of community action models being used. Only 3 of the 19 projects while identified by others as community capacity building projects, identified themselves as capacity building projects, although 10 claimed to be increasing citizen capacity. Of the 19, only 3 reported that the original idea came from the community (with the help of project staff), and 6 claimed that the community shared equally in decision-making. However 10 reported that the public involvement, whatever the level, was indispensable.

Respondents identified a variety of issues that suggest that training in the field is required. For example, some wanted to better know how to work with a community, how to use a facilitator, how to access the media, how to access data and so on. One expressed the desire to have such information easily available so each project would not have to start from "scratch".

2. Evidence Base & Theoretical Frameworks

Respondents identified the need for examples, models, availability of effective strategies around various issues (e.g., facilitating community change; building networks; getting professionals on-side; ways to get "main-stream" organizations involved; evidence around sustainability; etc.) and easy availability of this information. Nonetheless 13 respondents had used existing models to guide their work and 9 felt there was evidence available that it would work.

3. Collaboration with Other Agencies

Fourteen projects admitted that collaboration was essential, and 11 reported they had a defined governance structure, but only 8 said the partners shared a vision. However, it was felt by most (n=10) that the partners were at ease with community involvement.

4. Governance

Respondents felt the need for practical examples (models), guidelines on how to build a shared vision, guidance on resolving conflict between project needs and agency "policies", flexibility problems and liability issues.

5. Evaluation

Of the 19, 16 claimed to have clearly defined evaluation characteristics, but only 11 of the projects reported using standardized tools. Ten said they had no knowledge of innovative evaluation methods and 10 had difficulty establishing evaluation frameworks. Seventeen said the funders had requested interim evaluations but when details were provided these were mostly in the nature of interim progress reports. A few required activity measures, specifically the number of clients seen. Overall, only 1 respondent seemed to have developed an extensive evaluation framework. Others employed satisfaction surveys and "head counts". Nonetheless, 5 identified the use of an evaluator or consultant to help with the evaluation, and of these, 2 identified a specific evaluator as retaining ongoing responsibility for the evaluation.

6. Measurement

Respondents acknowledged that they could have benefited from help in many areas, such as the choice of indicators and analysis, access to expertise, knowledge of data sources, best practice guidelines, dealing with conflicting needs of funders, issues around data collecting by partners and how to choose methods that were not too time consuming.

7. Funding

Only 3 respondents admitted that the current level of funding was adequate, 8 reported they were managing and 6 reported it was inadequate. The availability of funding to keep the project going was an ongoing challenge and some felt they would have benefited from a list of funders from an interest in this area.

8. Sustainability

Seventeen projects reported they hoped the project would be sustainable, 16 had considered the requirements for this to happen, 13 had some idea as to who would provide ongoing funding, and 12 had involved the potential future funders in their project.

9. Would Guidelines for Community Capacity Building be Helpful?

When asked if guidelines would have helped, two thirds of respondents felt guidelines around engaging the community and setting up evaluation frameworks

would have helped, as would have availability of information regarding existing community capacity building models and related theories. Half of the respondents (n=10) felt guidelines to develop collaborative governance structures would have been helpful and a third (n=6) felt funding guidelines would have helped.

When asked what they had used that had helped guide their project in the first place, respondents reported a variety of resources, some specific to their area of interest and some more general, but generally few resources were identified.

# CHAPTER 7: CONCLUSIONS, LESSONS LEARNED & FUTURE RESEARCH

Our literature analysis, and other research conducted in this area to date, reinforce that the area of community capacity building is still in a state of development and presents many challenges for health professionals using this approach. Many fields share the area of community capacity building and many professionals have come to it from different backgrounds and directions, inventing or adapting terminology and approaches as they go. Community capacity building has only recently become recognized as a potential body of knowledge in its own right and still lacks a coherent basis of evidence. There are many problems that must be addressed and resolved prior to community capacity building being used as an accepted approach within a health context.

## *The Evidence . . .*

- there are currently no universally accepted definitions, processes, or evaluation indicators; terminology is often used incorrectly and inconsistently; the "right" language is often used but the approach is wrong and inconsistent with descriptions of process given
- most communitiy health programs are provided *in* a community or *for* a community but rarely *with* a community; rarely are decisions shared with a community & rarely is there a transfer of power & control
- a substantial numer of theoretical & conceptual frameworks exist & should be used to guide community capacity building initiatives, however few community capacity building projects have a solid evidence- or theory- based framework to guide community work
- the involvement of community members/citizens in the community capacity building process still varies significantly and sometimes, quite surprisingly, is missing entirely

## *Our Experience . . .*

- a community-systems approach is particularly well suited to capacity building initiatives related to health
- a community-systems approach requires organizations/ stakeholders & communities to become *equal* partners and *share equally* in decision-making from the beginning
- the current governance structure & operational practices of hospitals & health agencies *do* create issues of control, power, & ownership that significantly impact the community capacity building process
- in our work with seniors we have found that knowledge & use of existing theories, in particular theories of aging, individual & community empowerment & social psychological theories, can mean the difference between success & failure of community capacity building endeavors; this is particularly true when working with communities of very old individuals

The guidelines that should underpin community capacity building both in general, and as it relates to health, have yet to be pulled together into a specific discipline; there are many related topic areas that are founded in theory (and to a variable degree in evidence) and the contribution of these to the community capacity building process should be clearly identified; many authors have attempted to define the core components of community capacity building but no universal model has emerged; we have been unable to identify a clear structure laid out as being the essential framework for community capacity building, although many authors have offered suggestions in limited areas.

There continues to be conflict between the "top-down" vs. "bottom-up" approaches. This is a particular challenge within the health system. Several project authors have suggested that it is best to move along a continuum over the course of the project from initiating the project from a "top-down" approach to a completely "bottom-up" approach as project funding draws to an end. As one progresses along this continuum, decision-making power should be transferred completely to the community.

The interaction between communities and professionals raises many questions and is a particluar challenge when building community capacity in a health context. The projects analyzed identified decision-making power, including control over funds, as an essential ingredient in the community capacity building process. In several interesting cases, in which the projects failed, failure was attributed primarily to the ability of the funder (or the agency to whom the funds were granted) to veto decisions made by the community. Still others cite problems based on the perception that the partner who held the "purse strings" exerted more control than others. Transfer of power and control in terms of funding may be the single most important factor in empowering a community group. When academic, government and health partners play the role of "resource" to the community (as a facilitator, technical resource, information source, trainer or administrative support provider) it seems more likely that the community itself achieves greater power and decision-making capacity. Several project authors point out that this sort of involvement from an external source is often welcomed by the community and is even regarded as necessary to help maintain the focus of the community group on its objective.

## Hospitals Working with Communities . . . . . A Special Challenge

There is a growing body of evidence that suggests hospitals working with communities create an added challenge and that consistently endeavors led by

Hospitals are not successful.[112,113] It has been suggested[112-116] that this is due to hospitals, of all health care agencies tending to have the most defined hierarchical structure and vertical management and accountability arrangements. Despite using the right language senior management typically does not believe that it is in their best interest, or that of the hospital, to share health care decisions.

The "culture" of an organization has been reported as significantly influencing the success or failure of communtiy partnership building initiatives. Collaboration and participation are all about sharing decisions, control and power, the environment within which the change process occurs is critical. Researchers[112,113] suggest that successful and positive relationships are possible. However, they are dependent upon commitment by agency managers and senior management teams. It is not enough to have enthusiastic professionals on the front lines. Communities must share in decision-making and program ownership, and hospitals and agencies must recognize when to "let go", and be willing to "let go" of successful programs that have been built. Without this management commitment to share information, expertise and power, it is not possible to achieve sustainability.[112]

Much of the research to date, especially community capacity building initiatives, have focused on healthy, active and independent older individuals living in the community. There has been little emphasis on community members who are over the age of 75, who are much more dependent, have a greater number of health problems, and who are among the heaviest users of health services. In the present research synthesis (n=226) only 17 (8%) of community capacity building projects worked with a target population of seniors. None of the projects reported working with seniors 75 years of age or older.

## Funding Requirements Driving the Community Capacity Building Process

It is a recurrent theme that funding time lines are a problem for community capacity building projects. Many funding-related issues were identified through our research and the expert think-tank:

- current funding cycles & duration of grants are too short for community capacity building initiatives
- outcomes take too long to satisfy reporting requirements of most funders
- current funding policies & realities of issues don't "fit"

- funder & service provider mandates create barriers
- it is a challenge building & sustaining community capacity building projects by "grant shopping"
- a separate funding stream designated for community capacity building is needed
- improved co-ordination of funding across sectors is needed
- there is currently an unequal balance of funding; the majority of funding goes to institutions
- need funding to support sustainability of initiatives beyond the demonstration phase (this is the critical window)

We recommend that a 5-7 year tiered funding process be established that includes stepped funding for (1) program development, (2) actual program funding, (3) process improvement/sustainability funding and (4) a post-sustainability/accountabiltiy review to ensure that the original philosophy, guiding principles and outcomes are maintained following the integration of the new program into the existing system. Each level of funding should be dependent upon the clearly defined and successful outcomes of the previous level. Individuals or project teams who developed the orignal community capacity building project should be included as part of the evaluation team in the post-sustainability/accountability review.

## *The Evidence . . .*

- there is much evidence-based information about working with communities, facilitating change & factors that both enhance & constrain change initiatives

- facilitating change involves many issues that must be addressed, including communication, control, power & decision-making

- 4 key facytors have been identified as being critical to optimizing change & minimizing levels of resistance:

    1. the relationship between community & health system/agency
    2. the degree to which the community is involved in planning, goal setting, determining time lines, action planning, etc.
    3. the degree to which the community'sy priorities are consistent with those of the agency
    4. developing "true" partnerships & sharing decision-making

## *Our Experience . . .*

- partners for the most part are willing to think creatively, be flexible & collaborate to develop new programs & ways of operating; follow-through & implementation prove more difficult

- securing the required funds to work with a community for an adequate period of time is difficult; community capacity building & systems change is time intensive & cannot be done with "soft" funding; a minimum of a 5-6 year time commitment is required

- seniors (even the very old) & the communities within which they live have a great deal to offer the health system if the right approach is used & adequate support & resources are provided to build community capacity

## Community Capacity Building & Frailer Older Individuals

Very few (n=17; 8%) of projects analyzed worked with communities of seniors. None worked with frailer older individuals 75 years of age and older. Applying the concept of community capacity building in a predominantly older population provides additional challenges. The accumulation of age and disease has been identified as eroding the capacity of older individuals. Not only are older individuals faced with normal physiological decline that occurs with increasing age (e.g., increased health problems; reduced functional ability; reduced ability to cope with stressful events; etc.), but also with numerous additional losses imposed by society (e.g., loss of employment; reduced income; loss of one's role in society; etc.). During a time in life when psychological stresses are high, biological changes coupled with negative life events often lead to the inability of frailer older individuals to cope, and reduce involvement in community and/or societal activies. Numerous theories of aging support this concept. This presents added challenges and considerations for community capacity building. In fact, in our experience, our local Ontario Healthy Communities Coalition representative resigned from our community capacity building project after approximately 3 months stating:

*"this is the most difficult group I have ever worked with, I don't have time to be involved anymore!"*

Maintaining capacity in an aging community where the health of even the most active and involved members is somewhat precarious will be an ongoing challenge. A system of advocacy by "healthier" older community members on behalf of their frailer neighbours is needed. The frail, older individual, for example, may have an external locus of control, while the locus of control for the ocmmunity remains internal. For example, the problems experienced by frail older individuals are often seen as problems for the health care system to solve. If the care for frail older individuals is abdicated to the system the locus of control is outside the individual. With community capacity building, where the healthier community members help care for and advocate on behalf of the frailer members of their community, the locus of control may be outside the individual but at least it remains within the community. While the aging process itself is not reversible there are many factors in the lives of older individuals, which with the appropriate intervention and supports, can optimize the health, functional ability and involvement of older individuals. From a community capacity building context, it is important to examine "modifiable" factors which compromise the health and functional ability of older individuals and influence behaviour that is receptive to change by the individual themselves, by others such as friends, family members and neighbours, and through the intervention of helath professionals and community planners.

## *The Evidence . . .*

- older individuals with greater health & self-care needs will, out of necessity, be less able to participate as fully in community activities, including community capacity building initiatives
- there is a general consensus that community capacity building with older individuals, particularly communities of very old people, presents many challenges but that collaborative partnerships are possible
- successful partnerships require commitment by health professionals to shift power away from the traditional "top-down" role of the "professional" or "expert" providing intervention, to sharing decision-making & ensuring active & ongoing involvement by older individuals
- providing a supportive environment & a good understaning of the theories of aging will ensure that professionals help older seniors preserve enough energy to allow them to be meaningfully involved in their communities [1]

## *Our Experience . . .*

- community capacity building with communities of frail, older individuals works, however it is time intensive upfront & commitment must be made & adquate time allocated to work with community members
- seniors have valuable insight into the operation & short-comings of the health system; their feedback is valuable & reinforces the importance of the contribution they can make by actively becoming involved in health service planning & delivery
- seniors have different levels of comfort in dealing with the personal & health issues of their neighbours
- seniors are resourceful & derive much satisfaction from what they do & the opportunity to learn & grow
- younger, active & more independent seniors were more likely to become involved; although poorer health & functional ability inhibited involvement by many, these were not obstacles in older individuals who had a long history of volunteering[2]
- functional ability, activity level & social support resources are potentially modifiable factors which, if improved, could lead to greater involvement[2]

## What are Older Community Members Willing & Able to Do?

Seniors are most comfortable in providing information, being involved in the day-to-day operation of a health promotion centre, monitoring the health status of their neighbours and helping to plan and run psychosocial, maintenance/prevention and exercise program. They are not comfortable being directly involved in the medical and health problems experienced by their neighbours.[1]

## Theoretical Frameworks to Guide Community Capacity Building

Almost half community capacity building projects analyzed had no conceptual or theoretical framework to guide their work. A third of "theory-based" projects used processes inconsistent with the theories selected to guide their projects. This raises two issues: (1) lack of awareness or knowledge regarding what theories exists that will help guide community capacity building; and (2) fully understanding the various theories.

A substantial amount of evidence generated over the years across a variety of disciplines (including gerontology, psychology, health and sociology) is available to guide community capacity building initiatives.[1] These conceptual and theorietical frameworks provide useful insights into the constraints and enhancers of community involvement, change processes and community capacity as it relates to older individuals. The following conceptual and theoretical frameworks have proven particularly helpful in our work:

- Societal Change Theory
- Learning Organizations
- Individual & Community Empowerment Theories
- Community Systems Approach
- Theories of Aging
- Social Gerontological Theories
- Social Psychological Theories
- Theories of Volunteerism & Volunteer Behaviour

## THE DIFFERENT LEVELS OF COMMUNITY INVOLVEMENT: ARE YOU REALLY WORKING WITH A COMMUNITY?

There is consensus among researchers that many of the programs currently being provided are provided *in* the community, or *for* a community, but rarely *with* a community. Working with communities requires a commitment, among other things, to: (1) share decision-making; (2) share power; and (3) transfer more decision and program control/ ownership to the community (non-professionals). There are many levels of community involvement, and while health professionals often use the right "language" these concepts are rarely carried out in actual practice.[117-119] Of the community capacity building projects analyzed, almost half did not actively involve the communities/community members with which they worked. A growing body of evidence has identified that the majority of community partnerships tend to stop with satisfation surveys, and that the much higher levels of involvement (i.e. true participation and community empowerment) are rarely undertaken.

It has been suggested by some[119] that governmental policies that promote community empowerment are necessary to ensure active community participation in actual practice.

A number of projects in our current synthesis research pointed out that "true" community representation was most difficult to achieve. They cite difficulties with attendance (despite providing support such as transportation or day care), difficulties in actually getting community participation at meetings (lack of comfort on the part of community members who may be intimidated in meetings with government representaties, for example), maintaining consistent participation (community members seem more easily discouraged by *"process"* and tend to want to volunteer to take action on an issue of importance) and overloading community members already active as reasons for lack of truly "grassroots" participation. On several occasions cultural sensitivity was reported as a factor in engaging the community. Many communities already have established means of working together, establishing relationships and talking (or not) about issues. Fitting into previously established structures and being sensitive to community culture enhanced opportunities for community engagement and eventual success. There were several examples in which approaches were well defined, with a capacity building focus, but where projects failed to engage the community at all due to failing to consider cultural context. We are suggesting that community capacity building requires a skill that should be learned. The skill set could be part of the guidelines development.

# *Our Experience . . .*

## "Top-Down" vs. "Bottom-Up" Approach

Just as imposing a vision or way of doing things doesn't inspire change among a population, neither does asking an open-ended "what would you like to do" bring the best results. People make choices or decisions from what they know, from their existing repertoire and if that is limited, so too are the options from which they pull their suggestions.

In our experience, it is the combined approach of "top-down" "bottom-up", also called the community-systems approach, that yields the best results. From the top come the broad vision, the values and the possibilities. From the bottom, the general population, come priorities and preferences; but in this context, their choices are from the possible, not from the already tried. The engagement process brings synergy but more than that, it brings excitement and the sense of working together towards an uncharted objective. It is collaborative, community capacity building at its point of promise.

It is important to define whose capacity we are building:

- individual capacity?
- community capacity?
- organizational capacity?
- system capacity?

## The Special Problem of Evaluation

The single biggest challenge is evaluation of community capacity building initiatives. Of the 119 community capacity building projects analyzed in detail, 116 (98%) did not measure, or attempt to measure community capacity building, and 118 (99%) did not use any type of standardized tools. Much of the current evaluation is occurring at the *"individual"* level of analysis.

The issues of long-term outcomes remains essentially ignored. Although it is frequently assumed that community involvement will be beneficial in its long-term benefits, this remains to be demonstrated. For example there is the possibility that involvement in a community capacity building process, by frailer older individuals over the long-term, could increase stress, with long-term negative outcomes. There is little

if any, evidence that we and others are aware of, that links community capacity building with improved health outcomes; nonetheless many stakeholders believe they can identify a range of benefits. Progress in community capacity building seems to be based on consensus[67] with no references and no evidence in support of statements that are offered. In many situations it is unethical to conduct studies that are not likely to answer the questions posed; this can occur if the methodology or approach is unsound, a sample of participants is too small, the tools for measuring outcomes and success inappropriate, etc. It is important to apply such standards to community capacity building, avoid bias and use evidence- or at least theory-based processes. For community capacity building a top-down experimental model of evaluation (e.g., randomized controlled trial (RCT) is not feasible. A more appropriate approach to evaluation is the measurement of clearly defined and predetermined objectives; if community capacity building is the objective itself this MUST be measured. Community involvement in the evaluation process is critical.

There also continues to be an ongoing debate about community capacity building as "process" vs. "outcome". It would seem that the broader the definition of health, the more appropriate community capacity building seems to be as an outcome; the narrower the definition of the target health issue, the more appropriate it seems to use some form of community action as a process to help achieve the desired health outcome. However, evidence to support this is lacking.

Few community capacity building projects analyzed had pre-determined timelines for evaluation or indicators for success; few, if any, community capacity building projects measure outcomes at the collective community or community systems levels (this is linked to the question of community capacity building as "process" vs. "outcome" and needs to be addressed); there also continues to be tension between the use of qualitative vs. quantitative evaluation methods; clearly a combined method, using both, is required. Few articles and reports analyzed talked about goals related to community capacity building. If they did, the goals tended to be very broad such as "increasing empowerment". These papers rarely attempted to define outcome measures at all. If outcomes were presented they were often not related to the collective community, community capacity building or community systems partnerships. Most presented anecdotal information describing experiences or events that might illustrate or support ideas related to community capacity.

As part of the present synthesis research we also identified and reviewed published papers related to evaluation and community capacity building. A synthesis of the findings has been presented in Chapter 4 in an attempt to bring some structure to the evaluation process and to link it to the funding process. Even within this structure there is a further dissention relating to what to measure

This is where the project becomes very specific or, in addition to the general demonstration of capacity building, the indicators will be, by and large, specific to the health topic of interest.

## THE WAY FORWARD . . .

Despite the enormous value of community capacity building in many situations, it remains unclear if the process has any value in improving "health". We have suggested in this report that the area of community work and the concept of "health" are both so broad that developing guidelines in this area presents a significant challenge. A process is needed for narrowing our understanding of health as it relates specifically to Health Canada's mandate. Various levels of community work exist, and health is a multi-faceted concept. There is no agreement, nor is there any clear evidence, as to what type of community work will best lead to improvements in which facet of health. We suggest that this needs to be done and Health Canada should take a lead role.

We feel that there is an enormous amount of work and existing information developed by a number of key people[1,2,4,5,6,8,60,65,67,71,74,75,etc.] which could begin to form the basis of community capacity building guidelines. Health professionals working in the community have identified this as a need. Our recommendations relate to the beginning of a process to bring the various core components of the community capacity building process together into a uniform process and coherent discipline. The community capacity building field, as it relates to health, is young and still has much to prove. At this point agreeing on a standard terminology, set of definitions, processes, evaluation framework, and so on is the necessary next step. Only by such a process can the field move forward in a co-ordinated fashion and show what it is capable of.

## *Our Experience . . .*

### Goal Attainment Scaling (GAS)[120]

. . . a versatile & under-utilized evaluation tool that can actively involve community members & stakeholders in the evaluation process[109]

GAS provides a methodology:

- for setting goals
- creating a scale (-2, -1, 0, +1, +2) to objectively measure the degree of achievement, over- or under-achievement of goals established for various components of a project
- combining goal achievement scores for an overall project score

In our work GAS was found to be very "user-friendly" and readily understandable by elderly individuals and health professionals not familiar with program evaluation.

# *Our Experience . . .*

## Tool Box for Success

There are a number of practical tools that are useful when carrying out planning and implementing community capacity building initiatives.

At the planning stage, an inventory of existing programs, complemented by explanatory charts and maps, helps guide objectives and the implementation process by letting us know where services and activities currently exist and where gaps are evidence. When the program maps are overlayed with such items as demographics or the location of programs and services, or the location of natural environmental factors we have a much fuller picture of the community, its opportunities and possibilities.

Census data and trends for the larger community help put the smaller area into a larger context. Data about organizations and businesses in the geographic area provide still more information.

Tools for management and evaluation such as the balanced scorecard, program logic models, continuous process improvement, goal attainment scaling and more have also proven to be useful to ensure that we are responding to needs in ways that will take us to our desired outcomes.

The bottom line is that although a lot of what is written about community capacity building is philosophical and sociological, there is a spectrum of tools that will help us manage the process using "hard" (quantitative) data and processes. Adding qualitative data enriches our understanding and adding management rigor will give a better product and more meaningful, practical outcomes.

## *Our Experience . . .*

Levels of evaluation/units of analysis should include:

1. Individual Level (i.e., a change in knowledge, skills and/or involvement by individual community members, service providers and others; change at the individual level)
   - ☐ change in program recipient *function*
   - ☐ change in program recipient *knowledge & skills*
   - ☐ change in program recipient *involvement*

   - ☐ change in service provider *knowledge & skill*
   - ☐ change in service provider *involvement*
   - ☐ change in service provider/agency *policies*

   - ☐ change in other non-health professional *knowledge & skill*
   - ☐ change in other non-health professional *involvement*
   - ☐ change in other non-health professional/agency *policies*

2. Collective Community Level (i.e., the collective capacity of the community to identify issues and mobilize the resources necessary to bring about change)

3. Community-Systems Level (i.e., the ability of the "enabled" community to work together with the formal health system; ability to mobilize internal and external resources)

## *Our Experience . . .*

In our experience, and that of other researchers[75], community capacity building evaluation frameworks should, at minimum, include:

1. Pre-Project Analysis
   - 1a. Community Profile (e.g., demographic & soci-economic profile; health & functional profile; resource profile (i.e., asset mapping including identifying existing health programs, strategies currently being used, leaders in the community; existing systems or mechanisms in place to facilitate other communication & collaboration; other specialized studies/research; etc.)
   - 1b. Community Readiness & Potential for Capacity Building Evaluation (e.g., degree & type of existing community involvement; community awareness/knowledge of the topic to be addressed; interest & willingness to become involved/ collaborate; past experience with similar projects; potential barriers/problem areas; shared vision & goals; etc.)
   - 1c. Health System/Agency Readiness & Potential for Capacity Building (e.g., commitment of time & resources; commitment to share decision-making, control & ownership; commitment to "true" & ongoing community involvement; commitment to a collaborative governance structure; etc.)
2. Community Capacity Building (e.g., whose capacity building?; approach; target population; theoretical/conceptual framework (evidence base); level of, & strategies for, community involvement; mechanisms to ensure shared decision-making & control; collaborative governance structure; evaluation (process & outcome) time lines, indicators & standardized tools/approaches; etc.)
3. Post-Project Sustainability Evaluation (i.e., are the original philosophy, guiding principles and outcomes being maintained); if they have changed or evolved why? what is the evidence to support the need for the change? etc.)

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# APPENDIX A: LITERATURE REVIEW TEMPLATE

# Health Canada
# Community Capacity Building
# Synthesis Research

**Article Reference:** _____

(Full Reference Required) _____

_____

**Information Source:**

- ☐ published literature (peer-reviewed)
- ☐ published literature (non-peer reviewed)
- ☐ unpublished report/site developed documentation
- ☐ web-based information
- ☐ verbal/written information from key stakeholders & other key informants
- ☐ other: _____

**Name of Project:** _____

**Location of Project:** _____

**Contact Name & Address:**

_____

_____

_____

**Primary Sources of Funding:**

① _____

② _____

③ _____

④ _____

☐ Article doesn't specify sources of funding

**Target Population:**

- ☐ seniors:
  - ☐ 85+ years
  - ☐ 75-84 years
  - ☐ 65-74 years
  - ☐ 55-65 years
- ☐ children/youth/teens:
  - ☐ early years (0-6 years) ☐ with family
  - ☐ youth/children (7-12 years) ☐ with family
  - ☐ teens (13-18 years) ☐ with family
  - ☐ other age split: _____
- ☐ adults - general
- ☐ did not specify

**Geographical Project Boundaries:** _____

**Target Population/Community:** _____

**Sector/Focus:**

- ☐ Health (e.g., health promotion; prevention; community health; etc.)
- ☐ Human & Social Services (e.g., housing; poverty; crime; safety; etc.)
- ☐ Arts & Culture (e.g., cultural programs; arts councils; museums; etc.)
- ☐ Education (e.g., literacy; education programs; etc.)
- ☐ Environment (e.g., transportation; environmental issues; etc.)
- ☐ other: _____

**Focus of Work with Community:**

Project goals:

① _____

② _____

③ _____

④ _____

⑤ _____

**Project Time Lines:** _____ (Length of Project & Specific Dates Required)

## Project Design & Scientific Issues

**Definition of Community:**

*For the purpose of this study "community" is defined as being more than a shared geographic area and refers to a collection of individuals living in a particular neighbourhood/area with an established network to address common or shared interests. Collaborative action is used to respond to both individual, as well as broader neighbourhood/community interests and needs.* (Hawe, 1994; Lloyd, 1991; Shiell & Hawe, 1996) *Inherent in this definition is the notion of citizens caring about one another and working on individual as well as common concerns.*

Do the authors define what they mean by "community": ☐ yes ☐ no

If yes, how:

_____

_____

_____

If yes, is the authors' definition of community consistent with the study definition above: ☐ yes ☐ no

If the authors' definition is different, how does it differ:

_____

_____

_____

_____

**Approach:**

- ☐ *community-based program* (professionally identified need for program; program is designed, implemented and run by professionals; limited community involvement)
- ☐ *community action/community mobilization* (an issue introduced to a community from external sources; a high degree of collaborative community involvement; often community-driven)
- ☐ *community-systems approach* (community & external organization are equal partners; shared decision-making; "true" participation by community; all levels of stakeholders involved)
- ☐ *community capacity building* (specifically working with a community/community members to build their knowledge & skills to actively participate, take leadership roles & mobilize internal & external resources to address local issues of interest & concern)
- ☐ *community development* (no pre-set or fixed agenda or issue; community-identified issues; community-driven action )
- ☐ ***insufficient information provided***: _____

  _____
- ☐ other: _____

**Do the Authors Provide a Formal Definition of the Approach They Used in the Article?**

☐ yes ☐ no

If yes, what is the definition: _____

_____

_____

_____

_____

_____

**Level of Involvement/Participation by the Community:**

**Information**
*(top down flow of information)*

- ☐ 1-way flow of information; provider to consumer; purpose to increase knowledge

**Education**
*(top down flow of information)*

- ☐ 1-way flow of information; provider to consumer; purpose to change attitudes & behaviours

**Consultation**
*(2-way flow of information feedback channel)*

- ☐ 2-way flow of information; feedback sought; feedback may or may not be used
- ☐ client/consumer satisfaction surveys
- ☐ neighbourhood/community meetings

**POWER SHIFT TO COMMUNITY**

**Active Participation**
*(limited power & decision-making)*

- ☐ evidence of some shared decision-making
- ☐ "hand-picked" community members for committees
- ☐ active participation in program planning
- ☐ active participation in program implementation
- ☐ active participation in program evaluation
- ☐ attempt to influence policy

**"True" Empowerment**
*(transfer of power & control; community makes final decisions)*

- ☐ evidence of ongoing shared decision-making & planning
- ☐ on-going, long-term active involvement by the community
- ☐ evidence of transfer of power & control to the community; community members hold a clear majority of seats on committees with delegated powers to make decisions
- ☐ evidence that the community and/or its members "own" & operate the program(s)

**Primary Level of Involvement by the Community** (CHECK ONLY ONE):

- ☐ Information
- ☐ Education
- ☐ Consultation

---

- ☐ Active Participation — **ACTIVE COMMUNITY PARTICIPATION IN DECISION MAKING & PLANNING**
- ☐ "True" Empowerment

- ☐ insufficient information provided
- ☐ other: _____

? **Not a Community Capacity Building Project (DISCARD)** (community-based, information, education, consultation focus only)

? **Community Capacity Building Project (CONTINUE)**

**If the Level of Involvement is "*Active Participation*" or "*True*" *Empowerment*" What Specific Activities are Being Used to Facilitate Community Involvement & Build Community Capacity?**

① _____

② _____

③ _____

④ _____

⑤ _____

**Is the Project Theory-Based (Has the theoretical construct underlying the project been laid out)?**

☐ yes ☐ no ☐ some attempt, but not clear

If yes, which theories are being used:

① _____

② _____

③ _____

If yes, does the project fit the theory:

☐ yes ☐ no ☐ not sure

If no, why not: _____

_____

_____

_____

## Policy Considerations

**If the Level of Involvement is "*Active Participation*" or "*True*" *Empowerment*" has a Governance Structure Been Defined?** ☐ yes ☐ no

If yes, what is the structure: _____

_____

_____

If yes, are community representatives (citizens) included? ☐ yes ☐ no

**If the Level of Involvement is *"Active Participation"* or *"True" Empowerment"* do the Authors Provide Evidence of Commitment/Buy-In to the Project and its Goals by the Community?**

☐ yes ☐ no

If yes, what is the evidence that demonstrates community commitment:

_____

_____

_____

## Research Methodology

**Is a Defined Research Process being Used?** ☐ yes ☐ no

If yes, what is the research methodology being used:

Quantitative Methods:
- ☐ experimental design (RCTs)
- ☐ causal-comparative design (causality)
- ☐ correlational design (relationships)
- ☐ descriptive design (descriptive)

Qualitative Methods:
- ☐ interpretive phenomenology (experiences)
- ☐ focus group research
- ☐ other: _____

Combined Methods: _____

Other: _____

**Has a Method of Comparison Been Considered and Defined?** ☐ yes ☐ no

If yes, is the method of comparison:

a) *Internal* to the community: ☐ yes ☐ no

If yes, what is the method of comparison:

- ☐ pre-post comparison
- ☐ control group within the community
- ☐ other: _____

b) *External* to the community: ☐ yes ☐ no

If yes, what is the method of comparison:

- ☐ control group external to the community (other communities elsewhere)
- ☐ other: _____

## Evaluation Design

☐ **Statements in the Article Regarding the Success of the Project are Based on *Anecdotal Information Only***

☐ ***No Information/Evidence Provided to Support Statements* Made Regarding the Success of the Project**

**Have Outcome Measures/Indicators Been Identified in the Article?** ☐ yes ☐ no

If yes, what are the outcome indicators:

① _____

② _____

③ _____

④ _____

Are the Evaluation Indicators Specific to the Project Goals Established:

☐ yes ☐ no ☐ not enough information provided

If no, why not:

_____

_____

_____

**Level of Evaluation/Unit of Analysis:**

☐ *individual level* (i.e., a change in knowledge, skills and/or voluntary involvement by individual community members, service providers and other non-professionals; change at the individual level)

- ☐ change in program recipient *function*
- ☐ change in program recipient *knowledge & skills*
- ☐ change in program recipient *involvement*

- ☐ change in service provider *knowledge & skills*
- ☐ change in service provider *involvement*

- ☐ change in other non-professional *knowledge & skills*
- ☐ change in other non-professional *involvement*

☐ *collective community level* (i.e., the collective capacity of the community to identify issues and mobilize the resources necessary to bring about change)

☐ *community systems level* (i.e., the ability of the "enabled" community to work together with the formal health system; ability to mobilize internal and external resources)

If the unit of analysis is at the *collective community* or *community systems* level how is this being measured/what are the outcome indicators:

_____

_____

_____

**How is Community Capacity Measured:**

- ☐ not measured
- ☐ measured as follows: _____

_____

_____

**Are Standardized Tools/Approaches (e.g., Goal Attainment Scaling) Being Used to Measure Community Capacity Outcomes:** ☐ yes ☐ no

If yes, which tools/approaches are being used:

① _____

② _____

③ _____

References:

① _____

_____

② _____

_____

③ _____

_____

**Are *Pre-Determined* Time Lines for Evaluation Built into the Project Design:**

☐ yes ☐ no

If yes, what are the time lines: _____

_____

_____

**Major Obstacles/Barriers Encountered:**

① _____

② _____

③ _____

④ _____

⑤ _____

□ none identified in the article

**Innovative Ideas/Approaches/Key Finding Related to Community Capacity Building:**

① _____

② _____

③ _____

④ _____

---

**SUMMARY:**

Project has:

□ been published in a peer-reviewed journal

□ been published in a non peer-reviewed journal

? clearly defined goals

? pre-determined time lines for evaluation

□ used a clearly defined ***community capacity building*** (community development; community-systems; etc.) approach

□ a level of community involvement that falls in either the ***"active participation" or "true empowerment"*** categories

□ a theoretical base (where the theory fits the project)

□ a governance structure with community representatives (citizens)

□ clearly defined outcome indicators, specific to project goals, at the ***"collective community" or "community systems" levels***

□ used standardized tools/approaches to measure community capacity-related outcomes

# COMMUNITY PROJECT SURVEY

## Health Canada Community Capacity Building Synthesis Research

April 2003

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We are conducting a survey with the support of Health Canada to determine what information and tools might assist health professionals/agencies ***working with communities*** to build community capacity around specific health or service issues. Our ultimate goal is to develop "best practice guidelines" in this area, as well as an on-line site with a variety of resources related to community capacity building. In order to do this, we need your input. Please take the time to complete the following survey. Part 1 asks you questions about your project and the population with whom you are working. Part is designed to identify what information/resources you would have found helpful prior to beginning your community work.

If you have no specific community project underway or recently completed, we would still appreciate your feedback in completing Part 2. We welcome all suggestions you might have.

---

**PART 1: PROJECT PROFILE**

1. Name of project: _____

2. Contact name & address:

   _____

   _____

   _____

   _____

3. Project status: in progress completed

4. Project start date: _____

5. Project length: _____ years (full duration of project to completion)

6. Primary source(s) of funding: _____

7. Target population:

Seniors:
- 55-65 years
- 65-74 years
- 75-84 years
- 85+ years

Children/Youth:
- early years (0-6 years)
- youth/children (7-12 years)
- teens (13-18 years)
- other age split: _____

Adults-General

Other: _____

8. Primary goal of your project:

_____

_____

_____

9. Please check the box that ***best*** describes your project **(Please check ONLY 1 box)**:

*community-based health program*; health information, education or service need was identified and programs implemented by health professionals/agencies

*community action/mobilization project*; high degree of collaborative community involvement around a particular health topic, project or program

*a community-systems project* with a particular community and health institutions/agencies working collaboratively together as equal partners and sharing decision-making to address a particular health-related need

*a community capacity building project* with specific goals to build the knowledge and skills of community members' (individually & collectively) so that they are independently able to mobilize the necessary resources (both internal & external to the community) to address local health issues of interest and/or concern

*a community development project* with no pre-determined agenda or issue; community-identified issues and community-driven action

none of the above Please explain: _____

_____

10. Who identified/defined the problem(s) that led to your work with the community:

_____

_____

11. Who identified/defined the goals of your project:

_____

_____

12. If you are attempting to "build community capacity", who is the ***primary target*** of your "capacity" building project **(Please check ONLY 1 box)**:

community member/community/lay individual/citizen *capacity*
health professionals/agency *capacity*
organizational/system *capacity*
not applicable

13. Are the "primary targets" (see question 12 above) of your project involved in the planning and implementation your project:

yes no

If yes, approximately how many individuals or organizations are involved:

individuals _____
organizations _____

14. What obstacles/barriers have you encountered in getting your "primary targets" (see question 12) involved in your project:

_____

_____

_____

_____

15. Were you able to overcome these obstacles/barriers: yes no not applicable

If yes, how: _____

_____

_____

_____

***Engaging the General Public (e.g. Community Citizens):***

*If members of the general public (e.g. community citizens) are involved in your project please answer the next 3 questions. If not, please proceed to question 19.*

16. When did the *general public (e.g., community citizens)* become involved in your project **(Please check ONLY 1 box)**:

    the project was their idea
    the project was your idea, but the general public became involved very early on in the project
    the general public was involved part way through the project
    the general public is not yet involved in the project

17. What level of ***general public/community citizen*** involvement do you have:

    - ☐ members of the general public/community citizens are primarily involved in an advisory role
    - ☐ members of the general public/community citizens sit on, but don't lead, planning groups or committees
    - ☐ members of the general public/community citizens lead or chair planning groups or committees
    - ☐ members of the general public/community citizens share equally in project decision-making

18. How useful have you found the involvement of the *general public/community citizens* **(Please check ONLY 1 box)**:

    - ☐ indispensable
    - ☐ of some help
    - ☐ necessary but not really useful

***Measuring Project Success:***

19. Do you/did you have clearly defined evaluation indicators to measure the success of your project:

    yes no

    If yes, what evaluation indicators are you using to measure the success of your project:

    _____

    _____

20. Are you using any standardized tools, scales or other instruments to help you measure the success of your project: yes no

If yes, what tools, scales or instruments are you using:

_____

_____

21. Who defined the evaluation indicators used to measure the success of your project:

_____

_____

22. Who has overall responsibility for the evaluation of your project:

_____

_____

23. Have any interim evaluations/outcomes been requested by your funders:

yes no

If yes, what: _____

_____

_____

24. Are you aware of any innovative evaluation/statistical/analytical methods that you think would be helpful to others involved in similar projects that you would be willing to share:

yes no

If yes, what: _____

_____

25. Have you experienced any difficulties in establishing an evaluation framework (e.g., defining evaluation indicators; gathering data; etc.):

yes no

If yes, what difficulties have you experienced:

_____

_____

***Governance:***

26. Does your project require the collaboration of different agencies and/or institutions:

yes no

If yes, have you defined a clear, common governance structure:

yes no

If yes, do you feel the various collaborative partners have a *shared vision* for your project:

yes no some but not all partners

27. If community members or a particular community are involved in your project, have you found the other health partners/professionals at ease with the community's involvement:

yes no
some, not all community members are not involved

28. Have there been areas of particular difficulty that you have experienced regarding (e.g., decision-making; use of shared resources; accountability; reporting structures; working with communities or community members; etc):

yes no

If yes, what difficulties have you experienced:

_____

_____

_____

_____

29. Have you found any *innovative* solutions to overcome these difficulties; what have you found that works:

_____

_____

_____

_____

***Funding & Sustainability:***

30. Do you hope your project will be sustainable over the long term: yes no
*(If no, please skip to question 33)*

If yes, have you, or did you, consider the requirements for continuing your project beyond the current period of funding:

yes no

31. Do you have a clear idea who would fund the project if it did continue:

yes no

If yes, are these funders and/or agencies presently involved in your project:

yes no

If no, when and how are you planning to involve them:

_____

_____

32. Have you found the current level of funding adequate for both the scope and duration of your project:

yes no not ideal but managing

Comments: _____

_____

_____

_____

_____

33. Who benefits from the outcomes of your project:

_____

_____

_____

_____

_____

***Theory & Evidence:***

34. Did you use any existing models, conceptual and/or theoretical frameworks to guide your project: yes no

    If yes, what helped guide your project:

    _____

    _____

    _____

35. Is there evidence available to suggest that your project should "work" or are you trying to obtain that evidence **(Please check ONLY 1 box)**:

    evidence is available
    trying to build the evidence
    not applicable

36. Were you able to fully review existing models, evidence and/or theory related to your community work before beginning your project: yes no

37. How do you intend to share information about your project and its' findings with others:

    _____

    _____

    _____

    _____

**PART 2: WHAT WOULD HAVE BEEN HELPFUL?**

Looking back on your experience working in the community, what would you have found helpful before starting your project?

***Engaging the General Public (e.g. Community Citizens):***

38. Would you have found it helpful to have had "best practice guidelines" available to you (e.g., a community readiness scale; other tools; innovative and proven ideas to facilitate community engagement; etc.) at the start of your project:

    yes no

If guidelines had been available to help you at the outset, what would you have found *most* useful:

_____

_____

_____

_____

_____

***Measuring Project Success:***

39. Would you have found it helpful to have had "best practice guidelines" available to guide the evaluation component of your project (e.g., examples of evaluation indicators; a guide as to what to collect to satisfy the various stakeholders; data collection strategies; innovative ideas for analyzing your evaluation data; suggestions as to how to satisfy the needs of funders re: interim progress; etc.):

yes no

If evaluation guidelines had been available to you, what would you have found most useful:

_____

_____

_____

_____

_____

***Governance:***

40. Would you have found it helpful to have had "best practice guidelines" available to you (e.g., addressing such issues as shared accountability; building a shared vision; etc.) at the start of your project:

yes no

If guidelines had been available what would you have found most useful:

_____

_____

_____

_____

_____

***Funding & Sustainability:***

41. Would you have found it helpful to have had "best practice guidelines" available to you at the start of your project to help identify funding and sustainability issues and strategies:

    yes no

    If guidelines had been available what would you have found most useful:

    _____

    _____

    _____

    _____

    _____

***Theory & Evidence:***

42. Would you have found it helpful to have had "best practice guidelines" available to you outlining existing models, evidence and/or theories related to working with communities (e.g., community capacity building; facilitating successful community change; the community-systems approach to working with communities; individual vs. community empowerment strategies; developing community leaders; etc.) at the start of your project:

    yes no

    If guidelines had been available what would you have found most useful:

    _____

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**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY**

*Programme de recherche sur les politiques en matière de santé*
*Résumé du rapport final*

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| Titre : | **Recherche de synthèse sur les capacités collectives** |
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| Date de la fin du projet : | **Mai 2003** |
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| Institution : | **The Lawson Health Research Institute** |
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## *Résumé*

En mai 2002, Santé Canada a financé, par l'entremise du Programme de recherche sur les politiques en matière de santé, l'analyse des tendances relatives au renforcement des capacités collectives, la définition des problèmes et des lacunes et l'établissement de directives pratiques visant à éclairer les décisions stratégiques ayant trait au renforcement de ces capacités. Les groupes de personnes âgées et très âgées forment l'un des segments de la population dont la croissance est la plus rapide et ces personnes sont celles qui utilisent le plus les soins de santé. Le renforcement des capacités collectives peut avoir une importance particulière pour les groupes de personnes âgées car il permettrait, dans le cas de ces personnes, de compenser la perte de leurs capacités individuelles et d'élargir le rayon d'action du système de santé, notamment dans le domaine de la prestation des services de soutien. L'intérêt que suscite depuis peu le renforcement des capacités collectives est opportun et valable, compte tenu des limites du système de santé collectif et des demandes continues dont il fera l'objet puisque le nombre de personnes âgées fragiles augmentera dans un très proche avenir. Le renforcement des capacités collectives en est aux premières étapes de l'élaboration, en particulier dans le secteur des soins de santé, et notamment en ce qui touche aux personnes âgées. Nous nous sommes appuyés sur les expériences conjuguées que nous avons acquises grâce (1) au programme Cherryhill sur le vieillissement en santé, un programme de collaboration axé sur l'élaboration, la mise en application et l'évaluation d'un nouveau modèle novateur de prestation de soins de santé aux personnes âgées, (2) au projet « Modèles », une initiative visant l'acquisition de connaissances spécialisées en gériatrie dans les collectivités des soins de santé du sud-ouest de l'Ontario, et (3) à « Investir dans nos enfants », l'un des cinq sites de

démonstration provinciaux du projet « Premières années » ayant pour objectif de promouvoir la santé des jeunes enfants et de faciliter la formulation de politiques ayant trait à la santé des enfants. Aux fins de notre recherche, nous avons procédé à une analyse documentaire poussée ainsi qu'à une analyse des articles intersectoriels publiés et des rapports non publiés traitant du renforcement des capacités, nous avons formé un groupe de réflexion sur les capacités collectives réunissant un vaste éventail de professionnels de la santé, de bailleurs de fonds et de décisionnaires intervenant dans le renforcement des capacités et nous avons passé en revue les projets de renforcement des capacités collectives. Nos conclusions, fondées sur les résultats et l'expérience, confirment l'absence de « rigueur » dans le domaine du renforcement des capacités collectives de même que la nécessité de résoudre ce problème et bien d'autres encore avant que la validité de cette approche dans le contexte de la santé puisse être reconnue.

**Voici nos conclusions**

- à l'heure actuelle, il n'existe pas de définitions, de marches à suivre ou d'indicateurs d'évaluation unanimement acceptés pour ce qui est du renforcement des capacités collectives; l'utilisation de la terminologie n'est pas uniforme et est souvent incorrecte; en outre, il arrive assez fréquemment qu'on parle de renforcement des capacités collectives dans les projets mais qu'on ne respecte pas les principes intrinsèquement liés à cette notion.

- il n'existe pas de directives uniformes, cohérentes et unanimement acceptées qui permettraient d'orienter le renforcement des capacités collectives en général, ou dans le contexte de la santé.

- en ce moment, le renforcement des capacités collectives ne repose sur aucun fondement théorique cohérent ni sur aucune infrastructure et, à ce jour, les progrès enregistrés dans ce secteur sont le fruit de l'expérience acquise et des « précédents »; un certain nombre d'auteurs clés ont tenté de cerner des éléments cruciaux ou essentiels de la marche à suivre en vue du renforcement des capacités collectives; cette démarche semble toutefois en bonne partie fragmentaire et elle n'est pas coordonnée à l'échelon national.

- on suppose naturellement que le renforcement des capacités collectives est valable mais, l'évaluation faisant défaut, les résultats à l'échelon « collectif » ou à celui du système communautaire sont pratiquement inexistants.

- il y a une pénurie de données concernant les indicateurs et les mesures des résultats applicables aux groupes de personnes âgées et aux programmes de promotion de la santé destinés à celles-ci et l'évaluation de ces programmes est insuffisante.

- le secteur se caractérise par d'importantes lacunes en matière d'évaluation; les projets portent essentiellement sur la marche à suivre et se préoccupent rarement des résultats;

ce qui pourrait s'expliquer en partie par le facteur temps (long délai d'exécution, courte période de financement); en dépit du fait que bon nombre d'éléments et qu'une multitude d'indicateurs ont été cernés, le secteur n'a pas adopté d'approche normalisée en matière d'évaluation ni, jusqu'à présent, de marche à suivre graduelle favorisant l'élaboration de projets sur la base des résultats.

- notre tentative de passer en revue les usages établis au Canada a été plus ou moins couronnée de succès; les quelques répondants à notre sondage n'ayant indiqué aucun indicateur d'évaluation axé sur la saisie des réalisations ou sur les capacités à l'échelon collectif (macro-niveau).

- l'expérience que nous avons acquise jusqu'à présent confirme l'existence de paramètres bien définis relativement au renforcement des capacités collectives dans le cas des personnes âgées faisant partie de la collectivité; des démarcations nettes se dessinent entre ce que les membres ou les groupes de la collectivité sont prêts à faire ou en mesure de faire eu égard à la santé; *« une seule approche (p. ex. le renforcement des capacités collectives) ne peut convenir dans toutes les circonstances »;* compte tenu de la diversité des collectivités et des problèmes de santé, aucune approche ne peut être qualifiée de meilleure; à l'heure actuelle, nous ne pouvons pas définir clairement les caractéristiques des collectivités, les problèmes de santé; le genre d'approche vraisemblablement efficace ou l'éventuel rôle de la collectivité.

**Voici nos recommandations**

- l'élaboration de directives pratiques fondées sur des résultats ou une théorie, ou du moins qui seraient le fruit d'un consensus national, permettrait d'améliorer sensiblement le système de santé, et les professionnels de la santé, les bailleurs de fonds et les décisionnaires pourraient s'en inspirer et sélectionner les marches à suivre et les indicateurs d'évaluation qui cadrent le mieux avec leur secteur d'intérêt; à l'étape actuelle, il est crucial, à notre avis, de s'entende sur les pratiques exemplaires et les meilleurs modèles dans ce domaine, entre autres, sur des indicateurs composés d'évaluation prenant en considération à la fois la marche à suivre et les résultats.

- il est indispensable qu'on adopte des expressions communes et convenues; qu'on définisse les éléments cruciaux de chaque échelon de travail communautaire et qu'on en tienne compte dans la terminologie et les exigences en matière de subvention de Santé Canada et qu'on établisse clairement l'importance de l'engagement collectif, car celui-ci peut prendre diverses formes, depuis la formation de véritables partenariats jusqu'à la participation à un sondage.

- des attentes en matière d'évaluation doivent être définies tout comme des directives et des indicateurs uniformes doivent être élaborés dans ce domaine afin d'orienter les

initiatives collectives; de surcroît; on suggère d'adopter une structure de mise au point d'un cadre d'évaluation.

- la reconnaissance et le respect des directives devraient être un aspect essentiel de toute demande de financement; en l'absence d'une solide base de résultats, les directives fournies au secteur seront fondées sur la théorie et l'expérience pratique (consensus).

- le ministère devra revoir son mécanisme de financement, y compris les révisions fondées sur les directives et la reconnaissance du temps que nécessite la mise en œuvre de tels projets; un mécanisme de financement séquentiel devra être élaboré en vertu duquel on évaluera chaque étape avant de passer à la prochaine et de demander d'autres fonds.

- les professionnels du secteur sont conscients du caractère délicat de l'intégration d'une initiative au système afin d'en assurer la viabilité; des normes et un mécanisme de révision doivent être élaborés.

**Les opinions exprimées ici ne représentent pas nécessairement le point de vue de Santé Canada**

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En plus de ce résumé, vous pouvez obtenir le rapport des deux manières décrites ci-dessous.

- La version papier du rapport final complet est disponible dans la langue de soumission à la bibliothèque de Santé Canada, par prêt entre bibliothèques.
- La version électronique du rapport final est disponible sur demande dans la langue de soumission. Pour l=obtenir, écrivez à Santé Canada à l=adresse suivante : rmddinfo@hc-sc.gc.ca

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